COMMONWEALTH of VIRGINIA

JACK BARBER, M.D.
INTERIM COMMISSIONER

DEPARTMENT OF
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November 1, 2015

The Honorable Walter A. Stosch, Co-Chair
The Honorable Charles Colgan, Co-Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Stosch and Senator Colgan:

Item 314. B.2. of the 2014 Appropriations Act required the Department of Behavioral Health and Developmental Services to "*establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible"* and to *"report to Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2015"*.

Please find enclosed the report in accordance with Item 314.B.2. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan E. Massart
Mike Tweedy

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November 1, 2015

The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Item 314. B.2. of the 2014 Appropriations Act required the Department of Behavioral Health and Developmental Services to "*establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible*" and to "*report to Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2015*".

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November 1, 2015

The Honorable Terry McAuliffe, Governor
Commonwealth of Virginia
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Governor McAuliffe:

Item 314. B.2. of the 2014 Appropriations Act required the Department of Behavioral Health and Developmental Services to "*establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible"* and to *"report to Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2015"*.

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Item 314 of 2015 Appropriation Act
Paragraph B.2

Establishment of a Planning Process

to the Governor and the Chairs of the
Senate Finance and House Appropriations Committees

November 1, 2015

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I. INTRODUCTION

In 2014, the Department of Behavioral Health and Developmental Services (DBHDS) submitted to the Governor and the Chairmen of the Senate Finance and House Appropriations Committee a report reviewing the current configuration of services provided at the Commonwealth's adult mental health hospitals. This report began preliminary discussions surrounding the options for consolidating and reorganizing the delivery of such state services[1]. DBHDS will be further expanding upon reconfiguration options in a new report to be submitted this year[2].

Paragraph B.2. of Item 314 of the 2015 Appropriation Act (see below) requires DBHDS to establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible. This planning process must include various stakeholders from across the behavioral health landscape in Virginia and will produce a comprehensive plan that ensures there are quality services, both inpatient and community-based, delivered at the community level in every part of the Commonwealth. This report is DBHDS' response to the requirements included in budget item B.2.

Appropriation Language

Item 314 of the 2015 Appropriation Act states:

> *B.1. The Department of Behavioral Health and Developmental Services shall review the current configuration of services provided at the Commonwealth's adult mental health hospitals and consider options for consolidating and reorganizing the delivery of such state services. This review shall include: a programmatic assessment and fiscal impact of the long-term needs for inpatient services for geriatric, adult, and forensic populations; the fiscal impact of the reduction in geriatric census on first and third party reimbursement at facilities; and, the long-term capital requirements of state mental health facilities. The review shall also identify national best practices in the delivery of these types of services. The Commissioner, Department of Behavioral Health and Developmental Services, shall submit this review to the Governor and to the Chairmen of the Senate Finance and House Appropriations Committees by October 1, 2014.*
>
> *B.2. The Commissioner, Department of Behavioral Health and Developmental Services, shall establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible. This planning process will produce a comprehensive plan that ensures there are quality services, both inpatient and community-based, delivered at the community level in every part of the Commonwealth. The target populations to be addressed in this plan are adults age 18 and older who: (i) have mental health needs, (ii) may have co-occurring mental health and substance abuse problems, (iii) may be in contact with the courts systems, (iv) may require emergency mental health services, (v) may need access to acute or intermediate inpatient psychiatric hospitalization, or (vi) may require long-term community behavioral health and other supports. The planning process should identify the mental health and substance abuse services and supports that are needed to help persons remain in their home and function in the community and should define the role that the Commonwealth's mental health hospitals will play in this effort. The plan should establish and rank recommendations for community*

[1] Item 314 B.1. of the 2014 Appropriation Act, submitted November 5, 2014.

[2] Item 307R of the 2015 Appropriation Act, *Piedmont Geriatric and Catawba Hospital Study*, to be submitted to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2015.

and facility services and supports based on greatest priority and identify future estimated funding needs associated with each recommendation. The planning process shall include input from community services boards, state and private inpatient facilities, the Department of Medical Assistance Services, persons receiving mental health and co-occurring substance abuse services, advocates for mental health and co-occurring services, and any other persons or entities the Department of Behavioral Health and Developmental Services deems necessary for full consideration of the issues and needed solutions. The Commissioner shall report to Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2015.

Summary of 314 B.1

The DBHDS report for Item 314 B.1. of the 2014 Appropriation Act (see Appendix B) included a review of the current configuration of services provided at the Commonwealth's adult mental health hospitals. The 2014 report also addressed the evolving role of state mental health hospitals in the continuum of care, as well as national best practices. It reviewed physical plant and capital outlay considerations for state mental health facilities of varying sizes and assessed the fiscal impact resulting from a reduction in the geriatric census. This report builds upon last year's submission and the *Study of Piedmont Geriatric and Catawba Hospitals* required by Item 307 R of the 2015 Appropriation Act by providing the framework for a planning process that ensures quality inpatient and community-based services are delivered at the community level throughout the Commonwealth.

Summary of *Study of Piedmont Geriatric and Catawba Hospitals*

In DBHDS' *Study of Piedmont Geriatric and Catawba Hospitals,* DBHDS builds upon last year's B.1 report by more closely reviewing adult mental health hospital and community based services, hospital population needs and capacity at both the hospitals and in the community. Although the focus of the report is on Piedmont and Catawba Hospitals specifically, given the interconnectedness of our system facilities and services, DBHDS felt it necessary to review all of the adult mental health hospitals and all community based services concurrently. For example, changes in bed capacity or a facility closure will have impacts on other state facilities and community services. Such a holistic approach to adult mental health services is very important to create a comprehensive transformation plan for behavioral health services that will result in the most sustainable and economically efficient system and yield the best possible outcomes for Virginia and its residents with behavioral health needs.

Highlights among the findings of the *Study of Piedmont Geriatric and Catawba Hospitals* include:

- Virginia's adult state hospital capacity of 17.3 beds per 100,000 people is higher than national averages (15 per 100,000) and considerably higher than peer states and states with county or locally-based community service systems (12.4 beds per 100,000). Additionally, the percentage of state hospital beds in Virginia as a percentage of total beds (45.2 percent) is higher than the national average (40.6 percent). Virginia's per capita expenditure on mental health ranks 31st among the 50 states has not kept pace with state spending overall and has marginally declined over time. Total department expenditures were $93 per capita in 2013, while peer states range from $41 in Texas to $287 in Pennsylvania. The national average for per capita spending is $130.

- State mental health hospital ("state hospital") spending consumes a disproportionate share of DBHDS funds. In 2013, inpatient state hospital spending comprised nearly half (46 percent) of overall state mental health agency spending in Virginia. This exceeds the national average (29 percent) and the highest proportion of such spending among peer states (36 percent in Georgia and Texas). DBHDS maintained this level of spending on inpatient state hospital beds from $332 million in 2009 to $340 million in 2013.

- Virginia has not transitioned behavioral health funding from institutional care to community treatment as thoroughly as peer states or national trends. While Virginia spends approximately 41 percent of its behavioral health budget on community services, at $47 per capita, nationwide expenditures on community services make up 75 percent of total spending, with an average of $89 spent per capita.[3]

- State Hospital System

    - Analysis of hospital utilization patterns in the state reveals wide variation in local demand for beds, both regionally and by community services board (CSB). CSB utilization varies from less than three beds per 100,000 to over 46 beds per 100,000, pointing to inconsistent utilization management statewide. Demand is typically higher in rural areas where private beds are less available.

    - Hospital utilization and waitlist patterns demonstrate that the demand for acute care and forensic beds is steadily increasing, while demand for geriatric beds within Virginia's state hospital system have been decreasing. The number of geriatric patients has declined consistently from year to year, from an average census of 302 in FY 2012 to 269 in FY 2015.

    - The percentage of state hospital beds occupied by individuals involved with the criminal justice system continues to grow. Configuration of forensic beds will need to be adjusted in the future to accommodate this increase.

    - The current configuration of responsibilities for managing admissions and discharges does not incentivize behavioral health stakeholders to decrease hospital utilization. Because state hospital care is free to the communities, the financial incentives are in opposition to providing more care in the community.

    - State hospital overall utilization rates have steadily increased in the year following the civil commitment reforms, moving from 88 percent to 90 percent within 14 months.

    - Because of deferred maintenance at several state hospitals within the last decade, significant investment will be needed to retain or replace Virginia's current facility infrastructure and bed capacity, at considerable expense to the Commonwealth. Catawba and Piedmont alone will require an estimated $94 million in funding simply to maintain services at current levels.

[3] NRI State Profile data, FY 2013.

- Community Service System
    - Despite important achievements in developing the public infrastructure for community treatment, Virginia's funding structures and organization of community services continue to prioritize inpatient care over community treatment, resulting in inadequate access to services and significant deficiencies in the continuum of care. While total spending on mental health services in Virginia (approximately $726 million annually) is on par with peer comparisons, the distribution of spending between community and institutional care is not. The systems of care are not sufficiently coordinated or supportive of each other, and the opportunity cost of this is significant: A Virginia Office of the State Inspector General report from 2014 states that the annual average cost of care per recipient in the Virginia state hospital system is $231,161 while community services cost the DBHDS $27,027 per individual.[4]
    - Virginia's extraordinary barriers to discharge list (EBL) indicates that 10-15 percent of state hospital patients are clinically ready for discharge and could be appropriately treated in a community setting. This number includes 150 people on the Extraordinary Barriers List (been clinically ready for discharge in excess of 30 days) and another 60-70 individuals who have been clinically ready for discharge for less than one month.
    - Deficiencies in the community care continuum are the product of: having three Code mandated services (e.g. emergency services, case management, and discharge planning for state hospitals), significant variations in local priorities, capacities, funding, and the relatively high proportion of state general funds spent on state hospital care. An additional factor may be the insufficient coordination of service provider groups.

This report is meant to establish a planning process for how DBHDS and the Commonwealth can move forward with the steps necessary to strengthen the adult mental health hospital system.

II. THE TARGET POPULATION

This planning process is intended to address adults who are over age 18 and who:

- Have mental health needs,
- May have co-occurring mental health and substance abuse problems,
- May be in contact with the courts systems,
- May require emergency mental health services,
- May need access to acute or intermediate inpatient psychiatric hospitalization, or
- May require long-term community behavioral health and other supports.

[4] Virginia Office of the State Inspector General, "Discharge Assistance Program Performance Review", https://osig.virginia.gov/media/2475/2014-bhds-005dap.pdf, February 14, 2014, accessed August 31, 2015.

III. THE CURRENT SYSTEM

Virginia's Public Behavioral Health and Developmental Services System

The publicly funded behavioral health system in the Commonwealth provides services to individuals with mental health or substance use disorders, intellectual disability, or co-occurring disorders through state hospitals and training centers operated by DBHDS, hereafter referred to as state facilities, and 39 community services boards (CSBs) and one behavioral health authority, hereafter referred to as CSBs. CSBs were established by Virginia's 133 cities or counties pursuant to Chapters 5 or 6 of Title 37.2 of the Code of Virginia. CSBs provide services directly and through contracts with private providers, which are vital partners in delivering behavioral health (mental health and substance abuse) and developmental services. CSBs function as the single points of entry into publicly funded behavioral health and developmental services, including access to state facility services through preadmission screening, case management and coordination of services, and discharge planning for individuals leaving state facilities. CSBs advocate for individuals who are receiving or are in need of services. CSBs also act as community educators, organizers, and planners and advise their local governments about behavioral health and developmental services and needs.

While not part of DBHDS, CSBs are key operational partners with DBHDS and its state facilities. DBHDS contracts with, funds, monitors, licenses, regulates, and provides leadership, guidance, and direction to CSBs.

DBHDS operates eight state hospitals for adults: Catawba Hospital in Salem, Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Piedmont Geriatric Hospital (PGH) in Burkeville, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton.

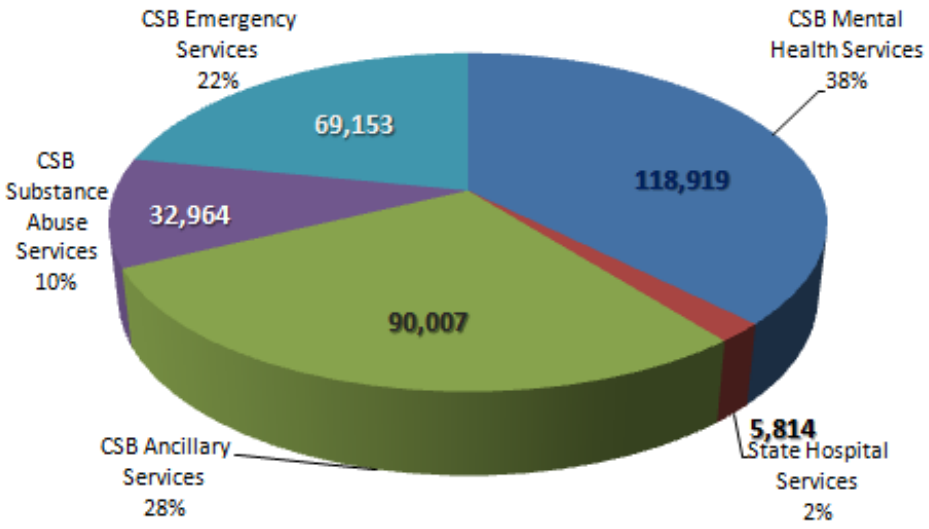
Title 37.2 of the *Code of Virginia* establishes DBHDS as the state authority for Virginia's publicly funded behavioral health and developmental services system. The DBHDS central office provides leadership that promotes strategic partnerships among and between CSBs and state facilities and with other agencies and providers. It supports provision of accessible and effective behavioral health and developmental services and supports by CSBs and other providers and oversees the delivery of services and supports in state hospitals and training centers. The central office also protects the human rights of individuals receiving services and assures that public and private providers adhere to DBHDS licensing standards.

Individuals Who Received CSB or State Facility Services

In FY 2015, 316,857 individuals received services in the publicly operated behavioral health services system: 311,043 individuals received services from CSBs and 5,814 individuals received services from state facilities. These figures are unduplicated within each CSB or state facility, but not across CSBs because an individual may have received services from more than one CSB; not between state facilities because an individual may have received services from

more than one state hospital or training center; and not between CSBs and state facilities because an individual may have received services from both. The figure below depicts the numbers of individuals who received mental health, substance abuse, emergency or ancillary (motivational treatment, consumer monitoring, early intervention, and assessment and evaluation) services from CSBs or state facilities and the respective percentages.

Figure 1. Individuals Receiving Behavioral Health Services in FY 2015



The following figure and table provide detail about the ages of individuals who received services from CSBs in each program area, emergency services, and ancillary services.

Figure 2. Ages of Individuals Served by CSBs in FY 2015

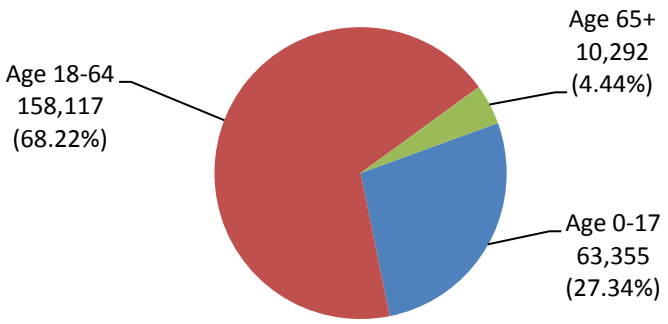


Table 1 below provides more detail about the ages of individuals who received services from CSBs in each program area, emergency services, and ancillary services.

Table 1. Ages of Individuals Who Received Services From CSBs in FY 2015

Age Range	Mental Health Services	Substance Abuse Services	Emergency Services	Ancillary Services
0 – 17	36,034 (30.3%)	2,035 (6.2%)	11,784 (17.0%)	33,632 (37.4%)
18 – 64	77,777 (65.4%)	30,652 (93.0%)	52,347 (75.7%)	54,576 (60.6%)
65+	5,092 (4.3%)	274 (0.8%)	4,737 (6.9%)	1,775 (2.0%)
Unknown	16	3	285 (0.4%)	24
Total	**118,919 (100%)**	**32,964 (100%)**	**69,153 (100%)**	**90,007 (100%)**

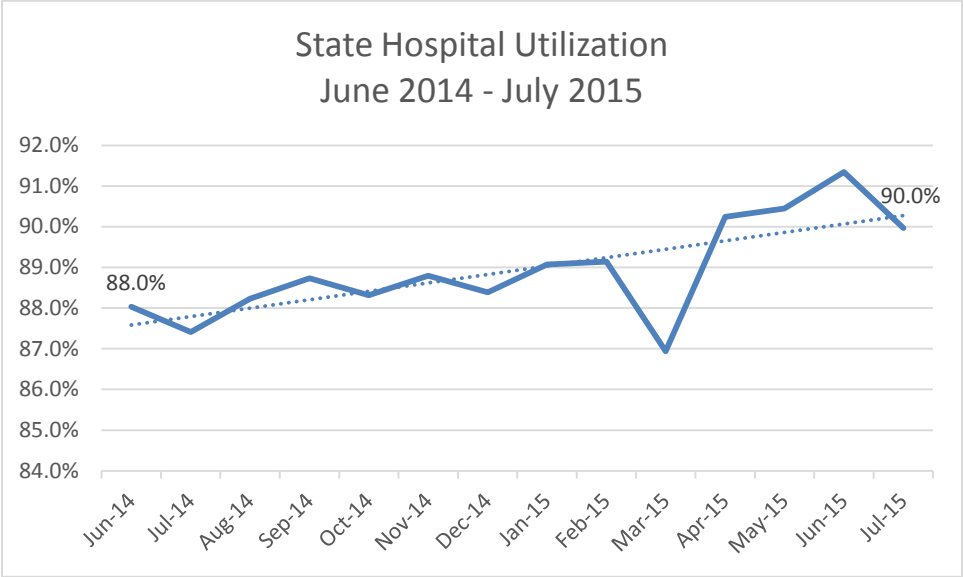
Description of State Hospitals

SB 260 from the 2014 Acts of Assembly became effective on July 1, 2014 to address specific concerns with the behavioral health crisis response system. In addition, regional partners, including CSBs, the local state hospital and local private partners, updated medical clearance and regional protocol guidance. Of critical and central importance was the implementation of new standards and protocols to ensure that no individual in acute psychiatric crisis, who was in need of temporary detention, would fail to receive that care due to lack of an available bed. This required substantial changes in policy, practice and operations to ensure that this critical, safety net service was available whenever necessary.[5]

Following the implementation of SB 260, the number of individuals admitted to state hospitals under a TDO as well as the number of individuals admitted overall has increased significantly, leading to an overall uptick in state hospital bed utilization. Shown in Figure 3, statewide utilization of inpatient treatment beds steadily increased in the year following these statutory reforms, moving from 88 percent to 90 percent within 14 months.

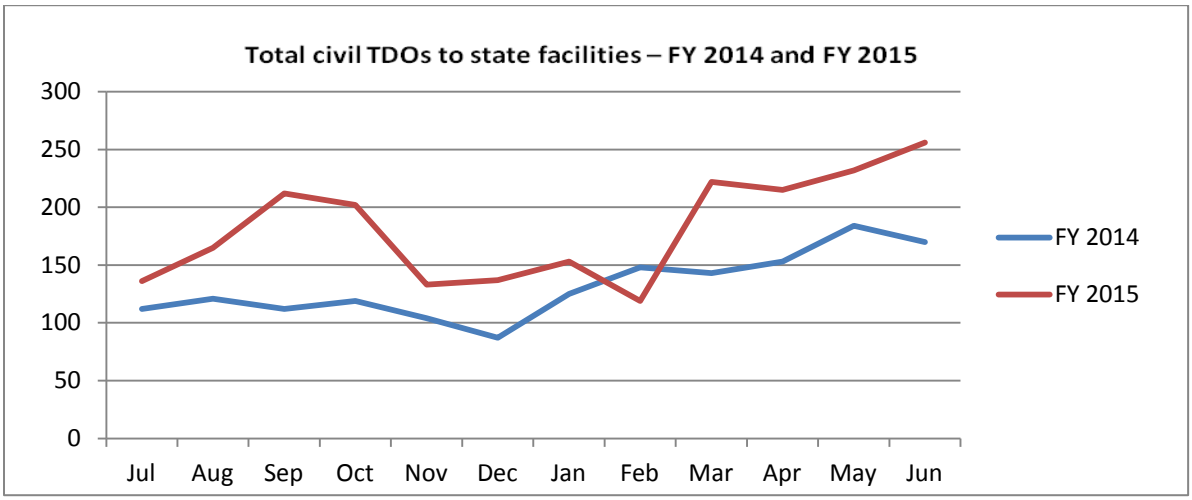
[5] These protocols are posted on the DBHDS website at http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/protocols-and-procedures

Figure 3. State Hospital Utilization – June 2014 – July 2015



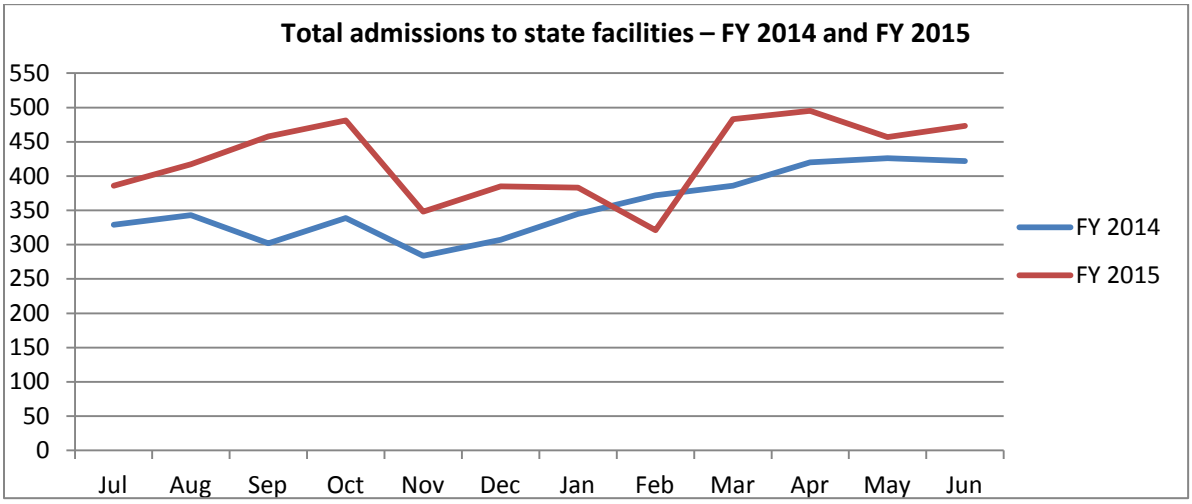
Shown in Figure 4, admissions under a TDO to state hospitals has grown by 38.9 percent in FY 2015 when compared with the number of admissions in FY 2014.

Figure 4. Total Civil TDOs to State Facilities – FY 2014 and FY 2015



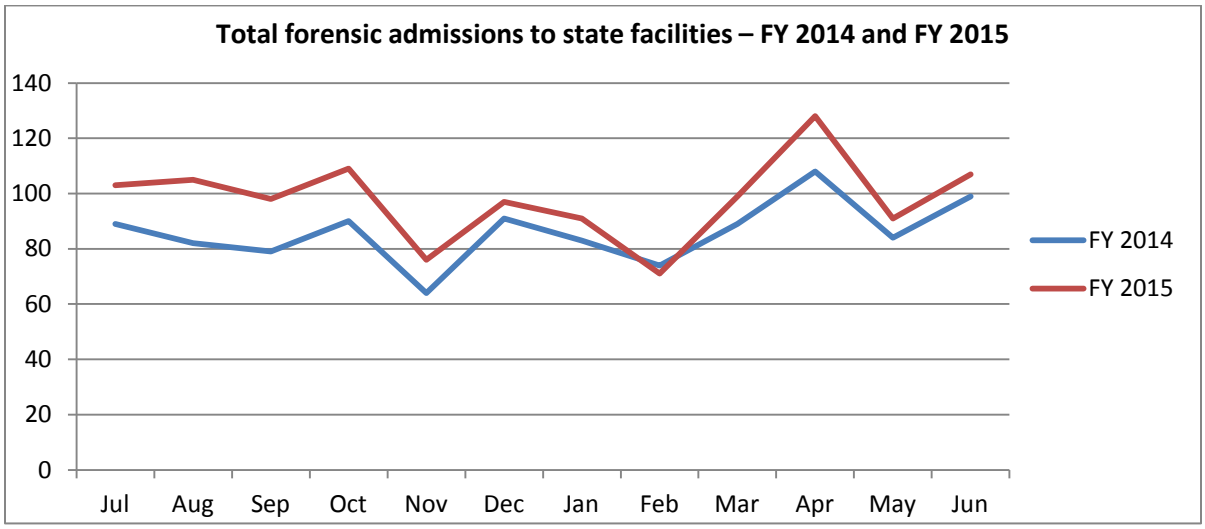
Shown in Figure 5, admissions to state hospitals overall has grown by 19 percent when compared with admissions overall in FY 2014.

Figure 5. Total Admissions to State Facilities – FY 2014 and FY 2015



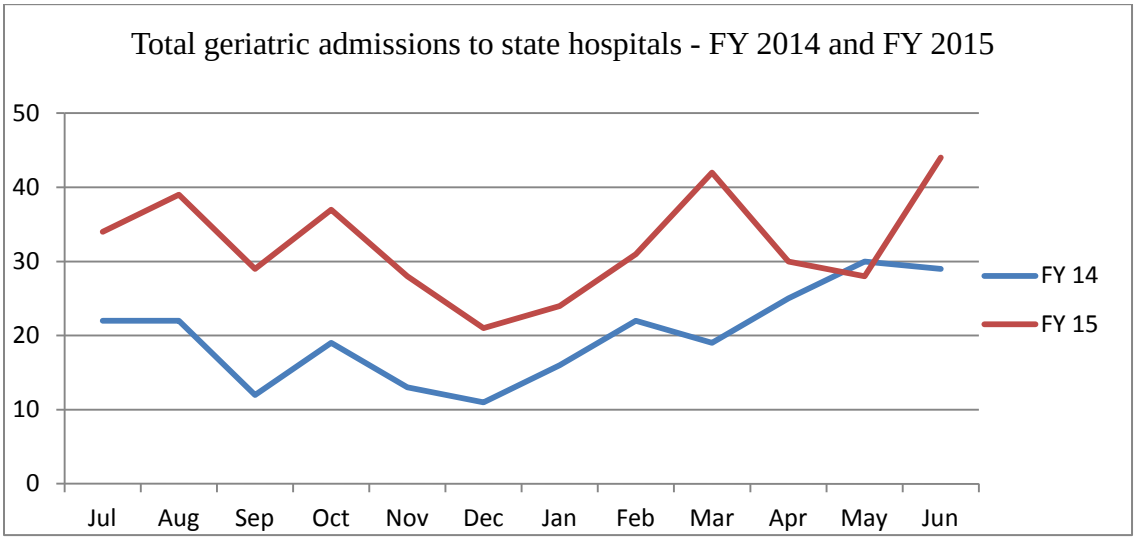
Shown in Figure 6, admissions under a forensic status to state hospitals overall has grown by 13.5 percent when compared with admissions under a forensic status in FY 2014.

Figure 6. Total forensic admissions to state facilities – FY 2014 and FY 2015



As shown below in Figure 7, geriatric admissions to state hospitals has grown by 61 percent in FY 2015 when compared with the number of admissions in FY 2014.

Figure 7. Total Geriatric Admissions to State Hospitals – FY 2014 and FY 2015



Catawba Hospital

Brief Overview of History and Population Served

Catawba Hospital, located in Roanoke County, serves forensically and civilly committed adults and geriatric individuals needing behavioral health care. The first priority for the facility is to help individuals regain and maintain their highest level of mental and physical functioning, with the ultimate goal of returning to community living. Catawba primarily provides treatment to adults in Partnership Planning Region VII, which includes one CSB, Blue Ridge Behavioral Health. Catawba serves geriatrics individuals from Alleghany-Highlands CSB, Blue Ridge Behavioral Healthcare, Horizon Behavioral Health, Harrisonburg-Rockingham CSB, New River Valley CSB, Northwestern CSB, Piedmont CSB, Rockbridge Area CSB, and Valley CSB.

Capacity and Utilization Snapshot

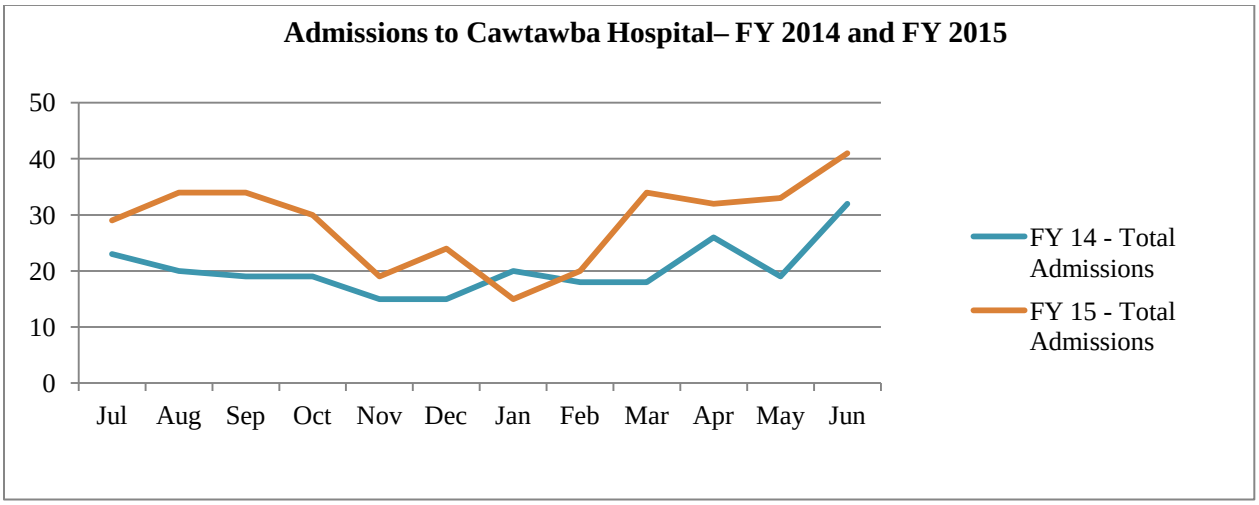
Catawba has an operating capacity of 110 beds. There are both Chronic Disease and Acute Intensive Psychiatric Certified beds in the facility. Currently, 12 percent of the Catawba capacity is used by 14 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 31 to 302 days. There are no individuals waiting for transfer from jail. The breakdown of Catawba's bed capacity is summarized in Table 2.

Table 2. Catawba Bed Capacity

Bed Type	Operating Capacity
Chronic Disease	60
Acute Intensive Psych Certified	50
Total	**110**

At Catawba, the average total utilization in the first week of the month during the review period of FY 2012 through FY 2015 was 84 percent, which is slightly lower than the statewide average of 86 percent. However, utilization at Catawba has increased steadily over the past four years and peaked in FY 2015 at 93 percent, which is 14 percent higher than in FY 2012 (79 percent). In FY 2014, Catawba had 244 admissions and 345 in FY 2015 which constituted a 41 percent increase in admissions over FY 2014. This trend is shown in Figure 8.

Figure 8. Admissions to Catawba Hospital – FY 2014 and FY 2015



Physical Facility

Catawba occupies 670 acres of property in a rural area of Roanoke County. It contains approximately 25 buildings constructed from 1910 to 1990. The main hospital building is an eight-story structure constructed in 1953 and contains approximately 140,000 square feet. Several of the hospital floors are not currently occupied.[6] The building recently received a major security systems and fire alarm system upgrade which are critical to assure safety. The building roof has also recently been replaced. However, the mechanical systems are beyond their useful life and will require major renovation to bring them into compliance with modern standards. The heating, ventilation, and air-conditioning systems are particularly challenging due to low floor-to-ceiling height in the building. While the windows were replaced several years ago and are very energy efficient, the windows on the patient floors lack the security imposed in modern structures at Eastern and Western State Hospitals.

Due to the remote nature of the site, this hospital has its own water treatment and sewage treatment facilities. The facility owns an extensive high voltage distribution system that must be maintained and makes it especially vulnerable to outages. The facility is served by its steam plant that is operated on fuel oil. While the facility is extremely well-maintained and operates with low energy usage, its inherent energy cost makes it one of the most expensive facilities to operate in the entire DBHDS system. In addition to the main hospital, there are approximately 25 other buildings on campus constructed between 1912 and 1996. The building that is in the best

1. DBHDS report to the legislature dated 12-1-2014

condition is the 9,000 square foot Patient Activities Building that was the most recently constructed. Many of the older buildings are vacant and abandoned. Efforts are underway to demolish several of the older buildings that are in a serious state of decay and contain hazardous materials.

Despite the recent upgrades to its security and fire alarm systems, Catawba's mechanical systems are in need of major renovations and the overall condition of the facility is fair. The capital costs to bring those systems up to modern standards and make the renovations necessary for Catawba to operate in the future is approximately $45.9 million.

Central State Hospital

Brief Overview of History and Population Served

Central State Hospital (CSH), located in Dinwiddie County, Virginia, responds to the mental health needs of individuals in Health Planning Region IV. While the facility does not maintain an acute admissions unit, they collaborate with Richmond Behavioral Health Authority, Chesterfield CSB, Crossroads CSB, District 19 CSB, Goochland-Powhatan CSB, Hanover CSB, and Henrico Area CSB to serve as a safety net for individuals under temporary detention orders. The hospital has the only maximum-security forensic psychiatry unit for the entire Commonwealth. The civil adult treatment program provides extended treatment to adults and provides services ranging from short term, quick re-entry to the community, to long-term intensive treatment for individuals with serious and persistent mental illness.

Capacity and Utilization Snapshot

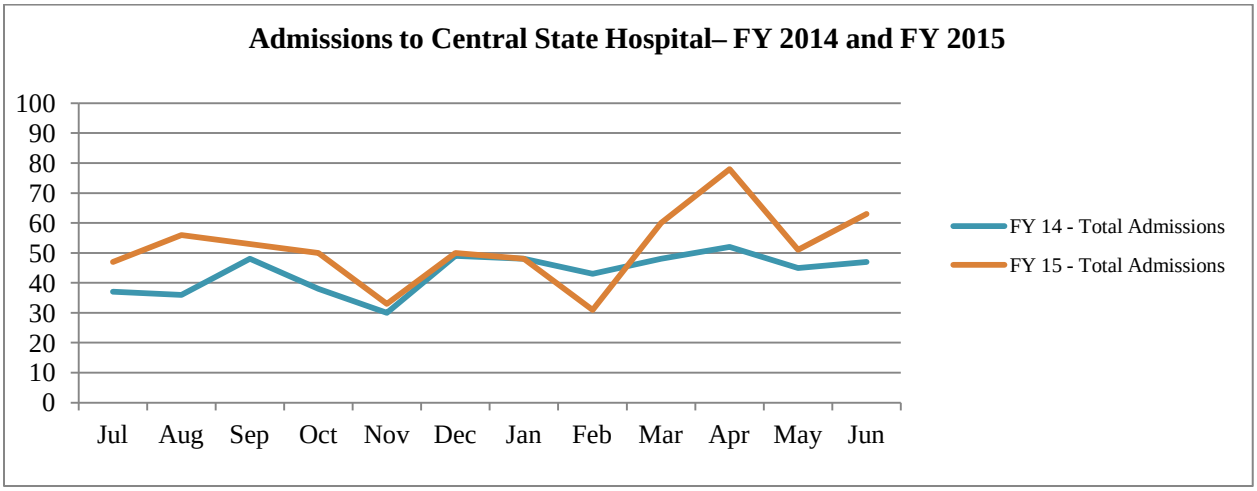
CSH operates at its maximum capacity of 277 beds. The facility has four different types of beds: Community Prep, Long Term Rehabilitation, Forensic Services-Medium, and Forensic Maximum Security. Currently, 7 percent of the CSH capacity is used by 20 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 32 to 549 days. As of October 8, 2015 there were 24 individuals in jail waiting for admission to CSH for evaluation or treatment to restore competency to stand trial. The bed capacity is broken down in the following Table 3.

Table 3. Central State Hospital (CSH) Capacity

Bed Type	Operational Capacity
Community Preparation – Psychosocial	50
Long Term Rehabilitation	50
Forensic Maximum Security	111
Forensic Medium Security	66
Total	**277**

At CSH, the average total utilization of civil, medium, and maximum security units in the first week of the month during the review period of FY 2012 through FY 2015 was 75 percent, which is much lower than the statewide average of 86 percent. However, while utilization at CHS steadily decreased from FY 2012 to FY 2014 to a low of 66 percent, it increased significantly in FY 2015 to 79 percent. This is an increase of 13 percent and brings CHS utilization almost back to the FY 2012 rate of 81 percent. In FY 2014, Central State Hospital had 521 admissions and 620 in FY 2015 which constituted a 19 percent increase in admissions over FY 2014. This trend is shown in Figure 9.

Figure 9. Admissions to Central State Hospital – FY 2014 and FY 2015



Physical Facility

CSH operates in many buildings that are old and beyond their useful life. Pre-planning funds have been approved to replace many of these buildings with a 300-bed facility similar to the new Western State Hospital. The current condition of this facility is poor and the cost of the replacement is estimated to be $137.1 million.

Eastern State Hospital

Brief Overview of History and Population Served

Eastern State Hospital (ESH) is located in James City County, Virginia. As part of Virginia's public mental health system, ESH serves adults, between the ages of 18 and 64, as well as geriatrics age 65 and above. The hospital primarily provides treatment for individuals in nine CSBs including Chesapeake CSB, Colonial Behavioral Health, Eastern Shore CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth CSB, Virginia Beach CSB, and Western Tidewater CSB, and Hampton-Newport News CSB.

Capacity and Utilization Snapshot

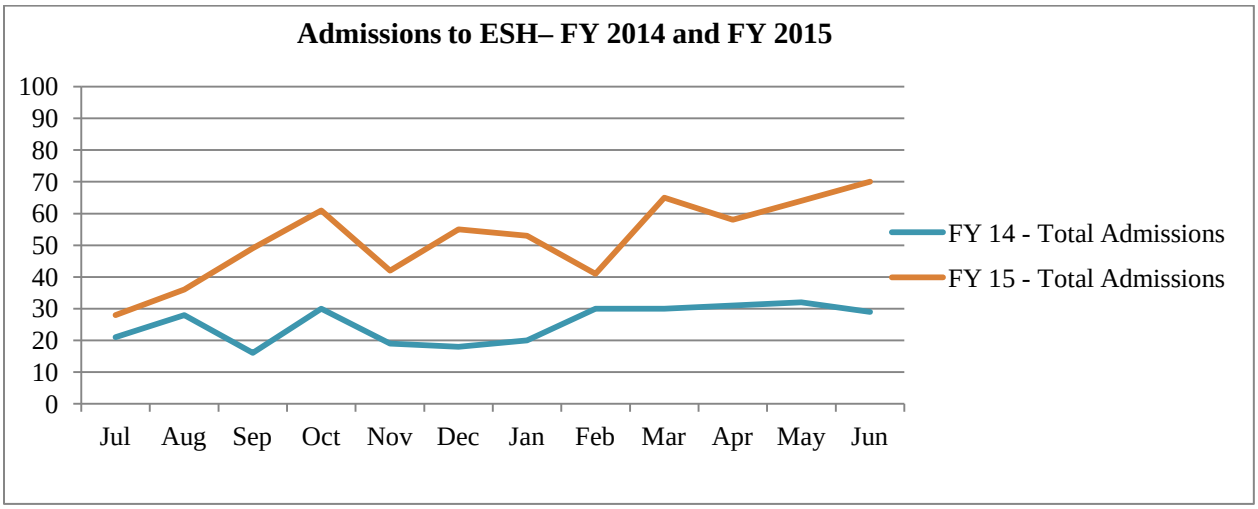
ESH currently has a maximum capacity of 302 beds. This total includes the addition of 20 beds, added at the end of 2014. The facility has four different types of beds: Acute Admissions, Forensic Services – Medium, Long Term Rehabilitation, Community Preparation and Nursing Facility. Currently, 15 percent of the ESH capacity is used by 44 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 31 to 1,804 days. As of October 8, 2015 there were 35 individuals in jail waiting for admission to ESH for evaluation or treatment to restore competency to stand trial. . The bed capacity is broken down in the following Table 4.

Table 4. ESH Capacity

Bed Type	Operating Capacity
Acute Admissions (IPT)	40
Forensic Services - Medium	127
Community Prep	55
Nursing Home	40
Total	**302**

At ESH, the average total utilization in the first week of the month during the review period of FY 2012 through FY 2015 was 89 percent, which is slightly higher than the statewide average of 86 percent. Utilization at ESH was relatively constant from July 2012 through July 2014 with an average of 88 percent; however, since 2014, the utilization rate has been rising and in FY 2015 the rate increased to 93 percent. In FY 2014, Eastern State Hospital had 304 admissions and 622 in FY 2015 which constituted a 105 percent increase in admissions over FY 2014. This trend is shown in Figure 10.

Figure 10. Admissions to Eastern State Hospital – FY 2014 and FY 2015



Physical Facility

The ESH campus currently contains approximately 747,000 square feet of buildings, of which 284,000 square feet has been declared surplus. That surplus is in the process of being sold. The remaining 463,000 square feet includes the Hancock Geriatric Center, which opened in 2008, and the Adult Mental Health Treatment Center, which opened in 2010. Those two newer centers account for 300,000 square feet of space and are in excellent condition. The remaining 163,000 square feet consist of older structures that are used for support functions and will need modernization in the near future. The overall condition of the ESH facility is very good. While there are no planned repairs or renovations with distinct costs, the planned Phase III expansion of ESH has an estimated cost of $30 million.

Northern Virginia Mental Health Institute

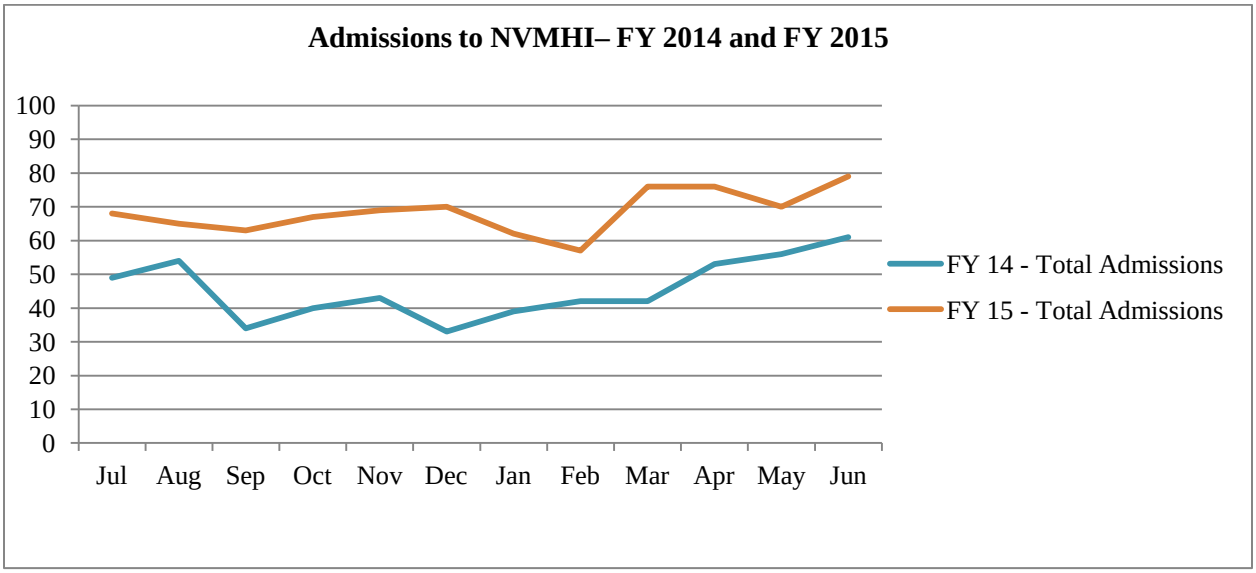
Brief Overview of History and Population Served

Northern Virginia Mental Health Institute (NVMHI) is located in Falls Church, and serves civil, forensic and voluntary adults between the ages of 18 and 65 years old who are in need of acute psychiatric treatment. Individuals eligible for treatment usually reside in one of the following five CSBs: Arlington, Alexandria, Fairfax-Falls Church, Loudoun, and Prince William. NVMHI accepts individuals on involuntary and voluntary admission status.

Capacity and Utilization Snapshot

NVMHI is classified as having Acute Admissions (IPT) beds. The current operating capacity is 134 beds. This total includes an additional 11 beds, added at the end of 2014. Currently, 12 percent of the NVMHI capacity is used by 16 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 92 to 802 days. There are no individuals waiting for transfer from jail. At NVMHI, the average total utilization in the first week of the month during the review period of FY 2012 through FY 2015 was 88 percent, which is slightly higher than the statewide average of 86 percent. Utilization has risen steadily since FY 2012 (86 percent) and peaked in FY 2015 at 91 percent, a 5 percent increase. In FY 2014, NVMHI had 546 admissions and 822 in FY 2015 which constituted a 51 percent increase in admissions over FY 2014. This trend is shown in the Figure 11.

Figure 11. Admissions to NVMHI – FY 2014 and FY 2015



Physical Facility

The original structure of NVMHI was constructed in 1975. It received a major addition and renovation in 1997. Additionally, a re-roofing project was recently completed. The building is in good condition, although the mechanical systems are generally beyond the midpoint of their expected life. NVMHI's facilities will need ongoing maintenance commensurate with the building's age, but there are no plans to make any major changes to the building's structure or conduct any major renovations at this time. It is important to note that the building is located on 10 acres of property with no opportunity for growth or expansion. It is surrounded on three sides by residential development.

Piedmont Geriatric Hospital

Brief Overview of History and Population Served

Piedmont Geriatric Hospital (PGH) located in Burkeville, Virginia, is the only state facility that exclusively treats geriatrics 65 years of age or older. PGH serves the following CSBs: Arlington, Alexandria, Fairfax-Falls Church, Loudoun, Prince William, District 19, Goochland-Powhatan, Hanover, Henrico, Richmond Behavioral Health Authority (RBHA), Danville-Pittsylvania, Southside, Rappahannock Area, Rappahannock-Rapidan, and Region Ten.

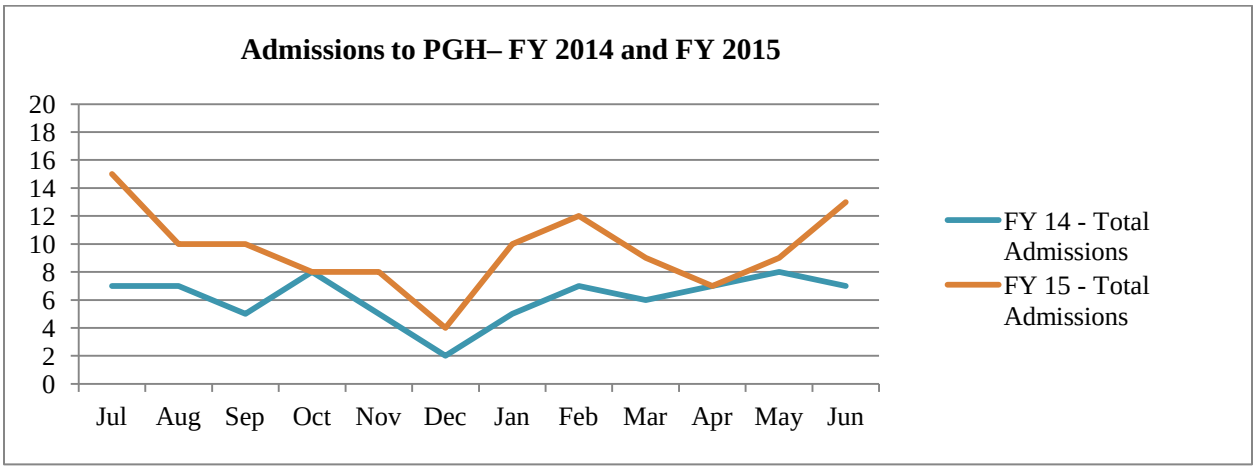
The patient population consists of individuals who:

- are in need of inpatient treatment for mental illness;
- meet the requirements for voluntary or involuntary admission as determined by their mental health center; and
- do not have a medical condition that requires priority treatment in an acute care hospital.

Capacity and Utilization Snapshot

PGH has a maximum capacity of 123 beds. Currently, 16 percent of the PGH capacity is used by 20 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 40 to 694 days. As of October 8, 2015 there were three individuals waiting for admission to PGH for evaluation or treatment to restore competency to stand trial. At PGH, the average total utilization in the first week of the month during the review period of FY 2012 through FY 2015 was 88 percent, which is slightly higher than the statewide average of 86 percent. Utilization at PGH has increased steadily since FY 2012 (85 percent) and peaked in FY 2015 at 95 percent, a 10 percent increase. In FY 2014, Piedmont Geriatric Hospital had 74 admissions and 115 in FY 2015 which constituted a 55 percent increase in admissions over FY 2014. This trend is shown in the Figure 12.

Figure 12. Admissions to Piedmont Geriatric Hospital – FY 2014 and FY 2015



Physical Facility

The main hospital was constructed in 1939 and contains 27,000 square feet. In 1951, a 103,000 square foot addition added the north and west wings. After an extensive audit, the facility showed numerous hanging hazards and other unsafe conditions. Upgrades were made to the patient care area in 2011 to comply with the "Plan of Correction" approved by the Center for Medicare and Medicaid Services. Kitchen upgrades have also been made as needed. While the mechanical, electrical, and plumbing systems are in adequate condition, they are well beyond the midpoint of their expected life and will be in need of replacement in the near future. Furthermore, the exterior envelope of the building is failing and requires extensive renovation. Planning for this renovation has been completed, and final design will be completed as funds are released.

The second active PGH building houses administration functions and contains approximately 35,000 square feet. It was constructed in 1950 as a nurse dormitory and has since been adapted to its current use. Its mechanical systems are beyond their useful life and the building windows are

in need of replacement. The remaining 23 buildings on campus range in age from 1924 to 1952. Many are vacant and unused. Additionally, the boiler plant was recently renovated to allow the facility to use renewable energy sources such as wood waste (i.e., sawdust) and native warm season grasses (i.e., switchgrass). This plan serves both PGH and the Virginia Center for Behavioral Rehabilitation.

The overall condition of PGH is fair. While recent upgrades have improved the facility, both the main hospital and administrative buildings have structural concerns caused by aging and deferred maintenance that need to be addressed promptly. PGH will require $38.8 million of renovations within the next five years.

Southern Virginia Mental Health Institute

Brief Overview of History and Population Served

Southern Virginia Mental Health Institute (SVMHI), in Danville, Virginia, provides services to civil and forensic adults between the ages of 18 and 64 with serious mental illness for Danville-Pittsylvania CSB, Piedmont CSB, and Southside CSB. Treatment is person-centered, using the principles of recovery to promote hope, self-determination, and empowerment. The primary goal is to maximize favorable outcomes for individuals served to ensure their successful reentry to their chosen community. Essential elements of treatment focus on self-direction, respect, responsibility, and the use of peer support.

Capacity and Utilization Snapshot

SVMHI has an operational capacity of 72 beds. The hospital has two types of certified beds, Acute Admissions (IPT) and Forensic Services – Medium. Currently, 18 percent of the SVMHI capacity is used by 20 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 32 to 942 days. There are no individuals waiting for transfer from jail. The bed capacity is shown in Table 10.

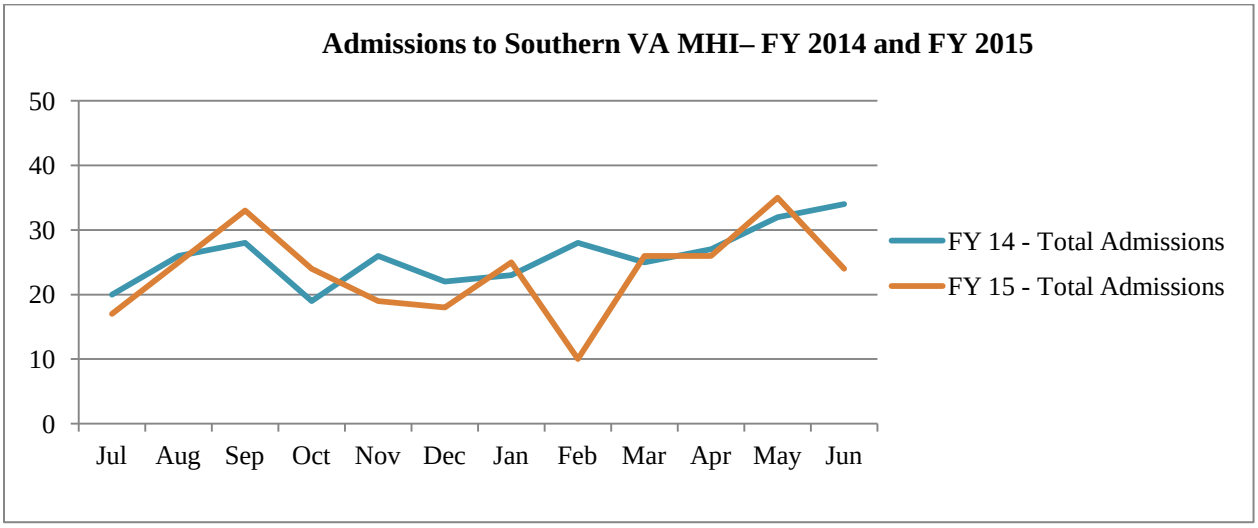
Table 5. SVMHI Capacity

Bed Type	Operational Capacity
Acute Admissions (IPT)	48
Forensic Services - Medium	24
Total	**72**

At SVMHI, the average total utilization in the first week of the month during the review period of FY 2012 through FY 2015 was 83 percent, which is slightly lower than the statewide average of 86 percent. Utilization at SVMHI has increased steadily from FY 2012 (74 percent) to FY 2014 (93 percent), nearly a 20 percent increase, but decreased to 84 percent in FY 2015. However, this is still a 10 percent increase from FY 2012. In FY 2014, SVMHI had 310

admissions and 282 in FY 2015 which constituted a 9 percent decrease in admissions from FY 2014. This trend is shown in the Figure 13.

Figure 13. Admissions to SVMHI – FY 2014 and FY 2015



Physical Facility

SVMHI's structure was built in 1975. It received a major upgrade of its mechanical systems and interior finishes in 2010. Additionally, the building received a new roof several years ago. The facility contains 70,000 square feet and is situated on approximately 20 acres of land. The main parking lot is in need of replacement, as are the fire alarm and security systems. Design is already underway for the replacement of those systems, although there are no plans yet to replace the parking lot. Overall, the condition of the facility is very good and will require $10.2 million in renovations in the next five years.

Southwestern Virginia Mental Health Institute

Brief Overview of History and Population Served

Southwestern Virginia Mental Health Institute (SWVMHI) located in Marion, provides treatment for individuals in the following six CSBs: Cumberland Mountain, Dickenson County, Highlands, Mount Rogers, New River Valley, and Planning District 1. The facility treats adults over the age of 18 as well as a number of individuals over the age of 65.

Capacity and Utilization Snapshot

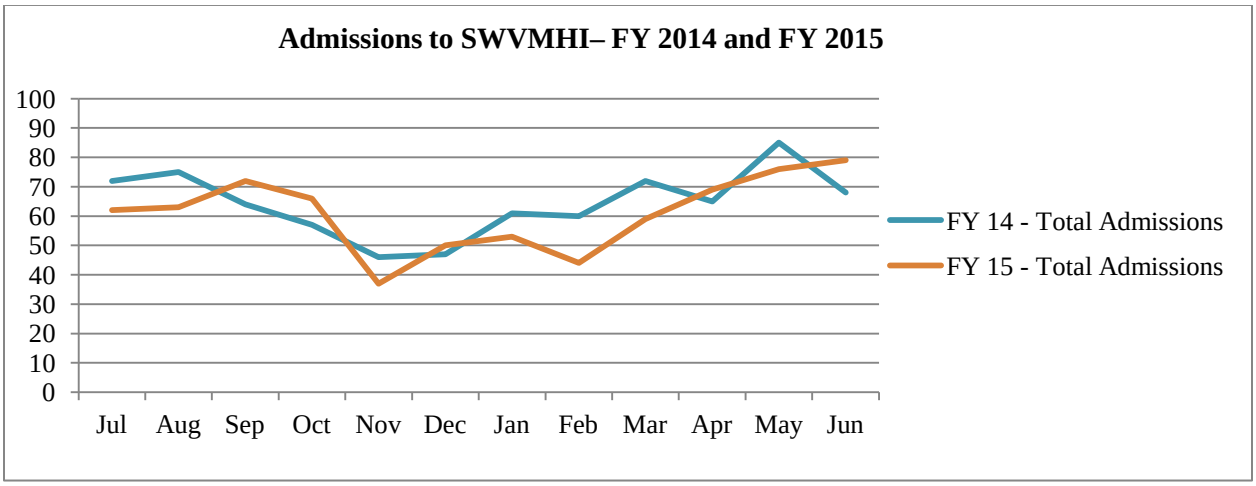
SWVMHI has Intermediate Care, Acute Psychiatric, and Community Preparation beds available. The facility currently has an operational capacity of 179 beds. This total includes an additional 17 beds, added in FY 2014 and FY 2015. Currently, there are no individuals on the extraordinary barriers to discharge list. As of October 8, 2015 there was 1 individual on a jail transfer wait list. The breakdown of capacity by bed type is included in Table 6.

Table 6. SWVMHI Capacity

Bed Type	Operational Capacity
Intermediate Care	20
Acute Admissions (IPT)	92
Community Prep	67
Total	**179**

At SVMHI, the average total utilization in the first week of the month during the review period of FY 2012 through FY 2015 was 92 percent, which is higher than the statewide average of 86 percent. However, while utilization at SWVMHI has remained relatively constant from July 2012 through July 2015, the rate has remained at about 90 percent or above during that period. In FY 2014, SVMHI had 772 admissions and 730 in FY 2015 which constituted a 5 percent decrease in admissions from FY 2014. This trend is shown in the Figure 14.

Figure 14. Admissions to SWVMHI – FY 2014 and FY 2015



Physical Facility

The main treatment area of SWVMHI contains approximately 100,000 square feet and was constructed in 1988. The building has recently received a new fire alarm and security system. While the main treatment building was built relatively recently, the main administration offices are housed in a building that is listed on the National Historic Registry and was constructed in 1887. That building received a new roof and skylight in 2014. In addition to these two buildings, the 110-acre SWVMHI campus contains 15 other buildings that vary in year of construction from 1910 to 1970. Some of these buildings have been vacated and are no longer in use. The campus water supply system is extremely old and in need of complete replacement. While the campus will continue to need maintenance reserve funding commensurate with the age of the structures, the overall condition of SWVMHI is good.

Western State Hospital

Brief Overview of History and Population Served

Western State Hospital (WSH) is located in Staunton, Virginia. In 2013, a new state-of-the-art, $140.5 million facility opened and patients were successfully transitioned from the old facility to the new one. The design of the new hospital incorporates special features that facilitate the delivery of highly-specialized, recovery-oriented treatment and provides a secure environment. This new setting not only enhances the provision of treatment, but also supports the development of the life skills needed for living independently within the community upon discharge. WSH treats forensic and civil committed adults' ages 18 to 64 years old. The facility primarily provides treatment for individuals in eight CSBs which include Horizon, Harrisonburg – Rockingham, Northwestern, Rappahannock Area, Rappahannock- Rapid an, Region Ten, Rockbridge Area, and Valley. WSH has also provided treatment for jail transfers from Arlington, Fairfax-Falls Church, and Prince William.

Capacity and Utilization Snapshot

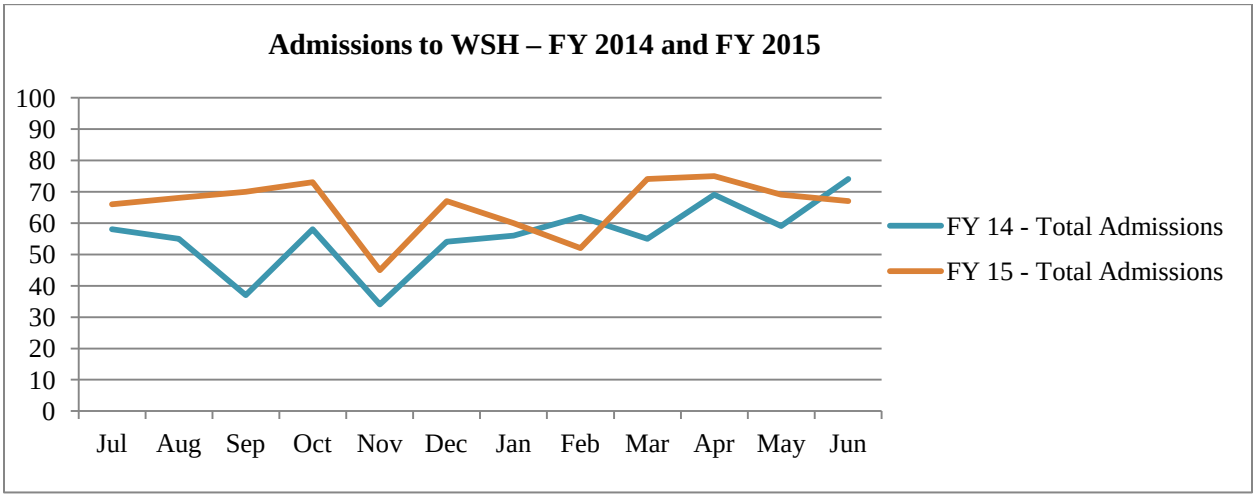
WSH currently serves four different levels of care: Clinical Evaluation, Forensic Services – Medium, Long Term Rehabilitation, and Acute Intensive Psychiatric. The capacity of WSH is 246 total beds. Currently, 11 percent of the WSH capacity is used by 27 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. Individuals on the extraordinary barriers list for this facility ranged from 34 to 523 days. As of October 8, 2015 there were seven individuals waiting for admission to WSH for evaluation or treatment to restore competency to stand trial. . Table 7 contains a breakdown of capacity by bed type.

Table 7. WSH Capacity

Bed Type	Operating Capacity
Clinical Evaluation	22
Forensic Services - Medium	28
Long Term Rehabilitation	112
Acute Admissions (IPT)	84
Total	**246**

At WSH, the average total utilization in the first week of the month during the review period from FY 2012 through FY 2015 was 90 percent, which is well above the statewide average of 86 percent. However, while utilization at WHS steadily decreased from FY 2012 to FY 2014 to a low of 86 percent, it increased significantly in FY 2015 to 94 percent. This is an increase of 8 percent. In FY 2014, WSH had 671 admissions and 786 in FY 2015 which constituted a 17 percent increase in admissions over FY 2014. This trend is shown in Figure 15.

Figure 15. Admissions to WSH – FY 2014 and FY 2015



Physical Facility

In 2013, WSH opened a new $140.5 million facility and patients were transferred from the old facility into the new one. The new campus provides approximately 360,000 square feet of the most modern and clinically appropriate mental health facilities in the country. The overall condition of WSH is excellent, and anticipated capital costs for the planned 56-bed expansion total $20.1 million.

State Spending on Virginia's Public Behavioral Health System

Disproportionate spending on facility-based services results in missed opportunities to maximize Medicaid leveraging for the state. General fund revenues are used to fund adult inpatient beds in state hospitals which can't utilize Medicaid reimbursement, unlike services along a holistic continuum provided in communities.

Modern mental health systems are characterized by robust community service infrastructures, making state hospital use infrequent and short. Community services include those provided through state mental health agencies and their local partners, private providers and community facilities housing inpatient psychiatric beds. The transition of public resources from state hospitals into community services has continued to play out in states since the 1950s with the aim of achieving better, more humane and more affordable treatment for persons affected by mental illness.

Compared to peer states and the nation as a whole, total state mental health spending in Virginia is sufficient but does not prioritize community services over state hospital expenditures. Peer states, and the nation as a whole, exhibit systems with fewer resources dedicated to state hospitalization, carrying less state bed capacity and attaining higher penetration rates for community services. Unlike the nation on average and most peer states, Virginia state spending through DBHDS is only marginally higher for community services than it is for state hospital

care. Furthermore, each of the peer states spend a greater proportion of total funding on outpatient care than all inpatient (state and community beds) in Virginia.

DBHDS total per capita spending is close to the national average and within the peer group of states. Total DBHDS expenditures were $93 per capita in 2013. Virginia ranks 31st among the 50 states in 2013 per capita state agency mental health spending, while peer states range from $41 in Texas to $287 in Pennsylvania. The national average for per capita spending is $130. Since 2009, DBHDS per capita spending has been relatively stable.

State hospital spending consumes a disproportionate share of DBHDS funds. In 2013, inpatient state hospital spending comprised nearly half (46 percent) of overall state mental health agency spending in Virginia. This exceeds the national average (29 percent) and the highest proportion of such spending among peer states (36 percent in Georgia and Texas).

DBHDS maintained this level of spending on inpatient state hospital beds from $332 million in 2009 to $340 million in 2013. These funds support nine state hospitals housing an average daily population of 134 individuals per facility or on average 5,259 individuals annually.[7] A Virginia Office of the State Inspector General report from 2014 states that the annual average cost of care per recipient in the Virginia state hospital system is $231,161 while community services cost the DBHDS $27,027 per individual.[8] The number of persons served in CSB community mental health programs over the review period averages 110,000 annually.[9]

Spending on DBHDS community programs increased by just 3 percent from 2009 to 2013 ($374 to $386 million). Funding for these programs made up over half (51 percent) of the DBHDS budget in 2013. Proportionally, state mental health agency spending on community programs is significantly higher among peer states and the nation, on average, compared to Virginia. The proportion of state mental health funding for community-based care in peer states is shown below:

State	FY 13 Proportion of State Mental Health Agency Funding Community-based Care
VA	51%
TX	61%
NC	65%
GA	64%
OH	78%
MD	74%
PA	90%
OR	66%
U.S. Average	68%

Source: Virginia 2013 NRI State Mental Health Agency Data

[7] 2012-13 CMHS Uniform Reporting System and 2013 State Hospital Analysis
[8] Virginia Office of the State Inspector General, "Discharge Assistance Program Performance Review", **https://osig.virginia.gov/media/2475/2014-bhds-005dap.pdf**, February 14, 2014, accessed August 31, 2015.
[9] 12 and 13 NOMS

IV. PLANNING PROCESS DEVELOPMENT

The ultimate goal of a planning process is to develop a comprehensive plan that ensures the availability of quality behavioral health services to address every level of consumer need in every part of the Commonwealth. DBHDS considered a great deal of sources in the development of the planning process, such as existing information and transformation efforts, data analyses leading to recommendations in the *Study of Piedmont Geriatric and Catawba Hospitals*, DBHDS Transformation Team recommendations, stakeholder input, and Virginia *Code* requirements.

Consideration of Existing Information and Transformation Efforts

The plan will build on a solid foundation of recent efforts, both within and external to the agency, to assess the current behavioral health system and offer recommendations for improvement. In addition to the 314 B.1 report previously submitted to the General Assembly in 2014, the plan will also draw on the findings of the *Piedmont Geriatric and Catawba Hospital Review*, DBHDS transformation team findings and recommendations, and the work of outside groups including the Governor's Taskforce on Improving Mental Health Services and Crisis Response and the Commission on Mental Health Law Reform.

DBHDS Transformation Teams

DBHDS is committed to a full-scale, comprehensive system transformation effort. This includes an increased emphasis in the key areas of accountability, transparency, strengthening communication among all stakeholders, collaboration with community partners, and systemic implementation of best practices.

In 2014, DBHDS convened small transformation teams from the behavioral health and developmental disabilities services system to begin developing a strategic plan for services, delivery, and infrastructure. Each team is co-chaired by a DBHDS staff member and a person who has personally experienced a behavioral health disorder or a developmental disability, or a family of a person with lived experience. The membership of the transformation teams include representatives from state agencies including the Department of Medical Assistance Services (DMAS), community services boards, state and private inpatient facilities, individuals receiving behavioral health or developmental disability services, advocacy groups, and managed care organizations, among others. The teams focused on four areas, including:

- Adult behavioral health
- Adult developmental services
- Children's behavioral health
- Justice-involved services

Each team has analyzed specific components of the behavioral health and developmental disabilities services systems, including challenges and opportunities for transformation within the current systems. In the spring of 2015, the teams prepared their first round of findings and recommendations. The stakeholder group provided consultations and four town hall meetings

were held across the Commonwealth to solicit feedback and public comment. Across all of the Transformation Team recommendations, the following "themes" were gleaned[10]:

- Formalize and fund core services and supports across a continuum of care – focus on the Right Services and the Right Place at the Right Time
- Require reimbursement for case management services
- Strengthen the community-based system of services and supports statewide
- Standardize quality of care expectations statewide
- Align and maximize effectiveness of available funding streams
- Harness the power of data across agencies in the Secretariat to utilize and improve health outcomes
- Integrate behavioral health with physical health and social services
- Strengthen the workforce to ensure access to services
- Promote through policy and reimbursement a person-centered approach to care, merging the activities and processes of mental health, substance abuse, and DD/ID with those of child welfare, juvenile justice, educational, and health services
- Develop and conduct customized trainings to organizations that interact with target populations – Employers, Schools, Jails, etc.

DBHDS has been able to use the first round of recommendations to inform its legislative and budget proposals. The round two recommendations are due in November 2015.

Stakeholder Involvement

Through its recent efforts transforming Virginia's behavioral health and developmental disability system, DBHDS has deeply benefitted from drawing from the knowledge and on the ground perspectives of state and community partners. For the purposes of the planning process, DBHDS has received input on critical system services from a number of sources:

DBHDS Transformation Team Membership

The planning process for services for adults with behavioral health disorders or forensic involvement includes only two of DBHDS' four transformation teams. The Adult Behavioral Health and Justice Involved transformation teams each consist of 15 stakeholders across Virginia who are experts in their fields. They also include state representation, such as the Department of Medicaid Assistance Services, and family members and individuals with lived experience, a perspective DBHDS considers critical to transforming the system.

In addition, the transformation process includes an 18-member Stakeholder Group that includes statewide advocacy group representatives, state partners and family members across the subject matter encompassed by all four of the transformation teams.

[10] Refer to the Transformation Team recommendations at the end of this report.

Hospitals and CSBs Site Visits

The Public Consulting Group (PCG) provided the research and analysis to provide recommendations for the *Study of Piedmont Geriatric and Catawba Hospitals.* As explained earlier in this report, because one aspect of the DBHDS system affect another, PCG took a comprehensive view of all of Virginia's adult state hospitals and the community services boards statewide. The comprehensive nature and timely, relevant information in this study informed the work assembling the planning process in this report. To gather firsthand information regarding the provision of behavioral health services in the adult state hospital system and in communities, PCG conducted site visits with the hospitals and with community services board (CSB) representatives in each region of Virginia.

Over the course of two weeks, PCG conducted site visits with seven state run adult mental health hospitals and held a phone interview with the eighth. At each facility, discussions were held with key staff to gain a firsthand perspective on hospital operations.

Visits were also conducted with representatives of CSBs from six different planning regions; these conversations were guided by a robust discussion tool, which included categories such as populations served, funding, utilization and discharge planning, and service deliver and capacity. Finally, PCG also held phone interviews with private providers to gain some perspective from that group around system strengths and challenges. These discussions revealed the strengths and weaknesses that many providers shared, and providing more information for PCG to use in making helpful, actionable recommendations.

V. PLAN STRUCTURE

Through the recent transformational efforts, the data analysis of the *Study of Piedmont Geriatric and Catawba Hospitals* and stakeholder input, DBHDS has the necessary information to proceed with a plan to provide geriatric, adult, and forensic mental health services as close to peoples' home communities as possible. This process would result in a plan to ensure there are quality inpatient and community-based services throughout the Commonwealth for adults with behavioral health needs.

Identification of Services and Supports

The most effective mental health and substance use disorder services and supports promote recovery, self-determination and wellness in all aspects of an individual's life. First, these services provide the necessary prevention and ongoing supports to allow people to live successfully in their communities, to secure meaningful employment and enable them to remain connected to their personal support networks. In addition, Virginia must provide the necessary safety net services to provide immediate help for an individual experiencing a crisis, and the effective treatment services to facilitate that person's recovery and safe return to his or her community. Finally, Virginia must ensure that individuals with serious mental illness are diverted from jail whenever possible and that those individuals with mental illness who must serve time in jail receive critical treatment services. These include:

Lower Intensity Services: Services that reduce demand for intensive services and hospitalizations

- Prevention and Early Intervention – Includes services such as: Education and outreach regarding strategies for behavioral health wellness, suicide prevention, smoking cessation, and early childhood interventions.

- Ongoing Treatment, Rehabilitation, and Support – Includes services such as: Outpatient mental health and substance use disorder services, psychosocial rehabilitation, tele-psychiatry, primary care integration and screening, and case management/care coordination, to linkages between services/entities such as primary care, housing, employment, schools and social services.

- Ancillary Services – Includes services such as: Housing and supported employment.

Higher Intensity Services: Services that are more restrictive, more expensive services provided when illness is more difficult to manage

- Crisis Stabilization and Emergency Services – Includes services such as: Crisis services, including mobile crisis and continuum, Crisis Intervention Team programs.

- Hospitalization – Includes services such as: patient services in state and private hospitals.

Services for individuals with Serious Mental Illness in Jail

Includes services such as:

- Standard screening and quality assessments
- Discharge planning with housing and employment integration
- Multiple opportunities (including pre and post booking) for diversion from jail.
- Provision for treatment in jails – Medication, substance use and mental health counseling and support.

Planning Workgroups

Workgroups would be established to develop a comprehensive plan to ensure these critical services are high quality and are delivered throughout the Commonwealth at both the inpatient and community levels, as appropriate. The actions of the workgroup would be an extension of DBHDS' intensive system transformation process and may result in changes to be implemented administratively or through budget or legislative action. Based on the needs and services identified through the planning process, the following workgroups would be necessary to concentrate on key elements of the final plan:

- Lower Intensity Services Workgroup
- Higher Intensity Services Workgroup

- Services for Individuals with Serious Mental Illness in Jail Workgroup
- Hospital Services and Barriers to Discharge Workgroup
- Financial Analysis Workgroup
- Administration Workgroup

Workgroup Membership

Workgroups would each consist of small teams led by DBHDS staff. They may also include DBHDS hospital staff, CSB representatives, and representatives from other stakeholder groups. In addition, the groups should provide opportunities for input from stakeholders including state and private hospitals, CBSs, the Department of Medical Assistance Services, persons with lived experience, advocates and other stakeholder groups as needed.

Workgroup Process

- The four **Services Workgroups** would meet for a maximum of six months. Each group would provide approximately five recommendations, with justification, for the services and supports needed to help people with behavioral health disorders remain in their home communities. These recommendations should be ranked in the order of greatest priority and should identify what actions Virginia must take in order to make these recommendations become reality. In addition, the hospital services workgroup should also define the role of Virginia's mental health hospitals in the effort to help people remain in their communities. After incorporating any stakeholder input, the workgroups would provide their work to the Financial Analysis Workgroup.

- The **Fiscal Analysis Workgroup** would provide funding needs for the recommendations provided by the four Services Workgroups.

- The **Administration Workgroup** would consider all of the recommendations of the four Services Workgroups and the funding needs from the Fiscal Analysis Workgroup and provide an overall, prioritized ranking of recommendations for community and facility services and supports needed to help people remain in their home communities. The Administration Workgroup would also review and provide the recommendation justification and any action steps needed to implement the recommendations from the four Services Workgroups. The result would be a plan to help ensure there are quality inpatient and community-based services throughout the Commonwealth for adults with behavioral health needs.

Measuring Outcomes and Success

DBHDS is committed to continue shifting Virginia's system from one that is institutionally based to one that provides the necessary community based services so people can live in and thrive in their own communities. A transformed system is accessible, engaging, and consistent across the Commonwealth. It features strong community services, increased access and engagement, better integration with primary care, housing, employment, and education, and

enhanced cultural competence – all of which lead to less reliance on hospitalizations, emergency room visits, crises, and disparities in health services or outcomes. The plan resulting from this planning process would provide another vehicle to measure how successful DBHDS is in transforming its behavioral health system. The following are examples of outcomes of a transformed system:

- Decreased medical and psychiatric hospitalizations
- Decreased medical and psychiatric emergency department visits
- Increased penetration rate to 70 percent (VA has a 22 percent penetration rate)
- Decreased emergency evaluations by 50 percent
- Decreased temporary detention orders by 50 percent
- Decreased number of people with serious mental illness who are in jail on misdemeanors by 50 percent
- Stable housing metric
- 200 fewer state hospital beds
- 85 or less than 90 percent occupancy in state hospitals
- No waiting more than seven days for services

VI. CONTINGENCIES AND TIMELINES

Several efforts underway and pending action from the General Assembly may cause DBHDS to alter its plans. It is possible that a future event or action may occur that would have significant impact on the structure of the plan or on the plan viability itself: Should such an event occur, DBHDS would take the following four steps:

1. Identify the event;
2. Assess the impact of the event on the system and the plan;
3. Develop possible alternatives to address the event's impact; and
4. Determine action steps to include the alternatives or adjust the plan's structure accordingly.

The following are examples that may require the adjustment of a plan:

Phase Two of Grant to Establish Certified Behavioral Health Clinics (CCBHCs)

In October 2015, DBHDS was notified it received a planning grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to help Virginia plan for the creation of certified behavioral health clinics, or CCBHCs. CCBHCs have remarkable potential and are a model for the future of our system. CCBHCs operate like Federally Qualified Health Center lookalikes for behavioral health. They must meet established criteria, deliver a complete set of pre-defined services and be certified by the state. Some of the required services for CCBHCs are crisis mental health services, primary care screening and monitoring, peer support and intensive community-based services to veterans. As part of Phase 1 of the grant, eight of Virginia's 40 CSBs have been selected by DBHDS to become CCBHCs, following a detailed

self-assessment. DBHDS will be working very closely with the eight CSBs to help them be state certified as CCBHCs.

After one year of planning and preparing, Virginia plans to apply for Phase 2, the demonstration phase. Only eight states among those who received the Phase 1 grant will be awarded Phase 2 Demonstration Grants. Should Virginia receive Phase 2, it will be an unprecedented opportunity to rebalance the system and improve quality, outcomes and patient experience. CCBHCs, and other investments in behavioral healthcare, will reduce general and psychiatric hospitalizations and emergency room visits. They help increase wellness, improve health outcomes, facilitate a greater integration of behavioral and primary healthcare, and improve the overall patient experience. As a result, the plan included in this report will need to be adjusted to accommodate for the work that will be accomplished through the CCBHCs and account for the significant changes that will occur as a result of this tremendous system change.

Delivery System Reform Incentive Payment (DSRIP) program

Another key transformational initiative geared toward community based services is the planning effort underway at the Department of Medical Assistance Services (DMAS) regarding the U.S. Centers for Medicare & Medicaid's DSRIP program. While DMAS is spearheading this initiative, DBHDS has been a party to the planning process and it is clear that the aims of DSRIP are very similar to those that the plan described in Item 314.B.2 is meant to address. The DSRIP initiative has been underway for several months and has involved input from stakeholders involved in all facets of the behavioral health system as well as a high degree of input from the general public.

The DSRIP initiative is heavily focused on improving access to and quality of care for Virginians by revamping the way in which Medicaid pays for services, seeking to adapt value based payments in lieu of fee-for-service payments that may incentivize the provision of unnecessary services. Beyond that, however, DSRIP includes components geared toward increasing community capacity to address the needs of individuals receiving services close to their homes, and thus over time, driving down the cost of health care, which directly corresponds with the strategic goals of both the 314.B.2 planning process and the DBHDS. Specific steps aimed at building community capacity include:

1) Training for Workforce and Caregivers and Peers
2) Statewide Crisis Management
3) Telehealth and telepsychiatry
4) Housing and Employment

Should Virginia apply for and receive the DSRIP waiver, this plan would need to be significantly adjusted by DSRIP infrastructure building efforts. DSRIP would allow Virginia to achieve system transformation goals and would ensure close collaboration between the agencies and all relevant stakeholders.

Action During the 2015 Session

Given the consultant and DBHDS recommendations in the *Study of Piedmont Geriatric and Catawba Hospitals*, it is possible that action may be taken to close a DBHDS hospital. Should

this scenario occur, DBHDS would adjust this plan to take into account *Code* requirements in § 37.2-316. This section requires DBHDS to establish a state and community consensus and planning team should the any DBHDS state hospital be designated to close or be converted to a use other than providing mental health services.

The team must consist of DBHDS staff and representatives of the localities served by the state hospital, including local government officials, individuals receiving services, family members of individuals receiving services, advocates, state hospital employees, community services boards, behavioral health authorities, public and private service providers, licensed hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested persons. In addition, the members of the House of Delegates and the Senate representing the localities served by the affected state hospital may serve on the team for that state hospital. The team is required to develop a plan that addresses:

> *(i) the types, amounts, and locations of new and expanded community services that would be needed to successfully implement the closure or conversion of the state hospital to any use other than the provision of mental health services, including a six-year projection of the need for inpatient psychiatric beds and related community mental health services;*
> *(ii) the development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs;*
> *(iii) the creation of new and enhanced community services prior to the closure of the state hospital or its conversion to any use other than the provision of mental health services;*
> *(iv) the transition of individuals receiving services in the state hospital to community services in the locality of their residence prior to admission or the locality of their choice after discharge;*
> *(v) the resolution of issues relating to the restructuring implementation process, including employment issues involving state hospital employee transition planning and appropriate transitional benefits; and*
> *(vi) a six-year projection comparing the cost of the current structure and the proposed structure.*

The plan must be submitted to the Governor and the Joint Commission on Health Care at least nine months prior to any proposed state hospital closure. DBHDS has kept this requirement in mind and has built elements into the planning process that can be expanded should there be a proposed closer of a DBHDS state hospital.

Should the decision be made to close Piedmont Geriatric and/or Catawba Hospitals, DBHDS has constructed a draft timeline for the development of community infrastructure and closure of the hospitals, per report recommendations, as follows:

DRAFT: Timeline for Development of Community Infrastructure and Closure of Piedmont & Catawba Hospitals

(Timeline would be finalized should the decision be made to close one or both of the above hospitals)

FY 2016		
2nd Qtr.	Plan for Stakeholder Engagement	
3rd Qtr.	Engage Stakeholders	
4th Qtr.	Continued Stakeholder Engagement	
FY 2017		Required Actions
1st Qtr.	Finalize and Implement Stakeholder Plans and Recommendations	
	Assess Need for Community Infrastructure for Catawba's Adult and Geriatrics	• Identify community needs and develop plan for transitioning geriatrics to the community and divert admissions • Identify opportunities to support BRBH to respond to the needs of individuals in crisis through community based services to reduce the need for acute care beds
	Establish State & Community Consensus & Planning Team (SCCPT) for Catawba	
2nd Qtr.	Plan for Catawba's Workforce Needs	• Human Resources to develop a plan for employees to identify other job opportunities
3rd Qtr.	Implement Plan for Community Infrastructure for Catawba's Adults and Geriatrics	• Create detox /crisis stabilization beds for BRBH with sufficient resources to work with more challenging/complex individuals • Create continuum of residential services for adult SPMI within BRBHA's service area • Create continuum of services for geriatric individuals
	Assess Need for Community Infrastructure for WSH adults	• Identify community needs and develop plan I to transition adults to the community and reduce admissions
4th Qtr.	Implement Catawba Workforce Plan	• Implement Human Resources plan to support employees affected by the closure
	Transition of Catawba's Adult and Geriatric Patients To Community	• Transition adult and geriatric individuals as appropriate into community based services and reduce admissions to Catawba
FY 2018		Required Actions
1st Qtr.	Create Enhanced Community	• Implement plan to transition adults to the community and reduce admissions to

	Infrastructure for WSH adults	WSH • NVMHI admits more jail transfers from its catchment area to reduce the census at WSH
2nd Qtr.	Stop Adult and Geriatric Admissions to Catawba	• 56 new beds come online at WSH • New adult admissions go to 23 bed new admissions unit at WSH along with any adult patients • New geriatric admissions go to new 23 bed geriatric admissions unit at WSH
	Establish State & Community Consensus & Planning Team (SCCPT) for Piedmont	
3rd Qtr.	Close Catawba Stop Admissions to Piedmont	• Piedmont admissions go to WSH's new geriatric admissions unit
	Assess Need for Community Infrastructure for Piedmont	• Identify community needs and develop a plan to transition geriatrics to the community and divert admissions; • Develop a plan for public/private partnership to serve the needs of individuals transitioning from PGH to the community
	Plan for Piedmont's Workforce Needs	• HR will develop a plan for employees to identify other job opportunities
4th Qtr.	Implement Plan for Workforce needs	Implement HR plan to support employees affected by the closure
	Implement first phase of plan for community infrastructure	Transfer 20 patients into the community
FY 2019		
1st Qtr.	Implement second phase of plan community infrastructure	Transfer 30 patients into the community
2nd Qtr.	Implement third phase of plan community infrastructure	Transfer 30 patients into the community
3rd Qtr.	Implement final phase of plan community infrastructure	Transfer 20 patients into the community
4th Qtr.	Close Piedmont	Transfer 20 patients into the community
FY 2020		
1st Qtr.		
2nd Qtr.		
3rd Qtr.		
4th Qtr.		

*Entire plan is based on the assumption that 56 beds are added to Western State Hospital

State & Community Consensus & Planning Team (SCCPT) for Catawba

SCCPT Member	Name	Title & Agency	Phone Number	Email Address	Notes
DBHDS Staff					
Local Government Official					
Individual Receiving Services					
Family Member					
Advocate					
State Hospital Employee					
Public Provider					
Private Provider					
Licensed Hospital					
Licensed Hospital					
Local Health Department Staff					
Local Social Services Staff					
Sherriff's Office					
Area Agency on Aging					
Senate Representative					
House Representative					
CSB – RBHA					
CSB - Harrisonburg-Rockingham					
CSB - Horizon					
CSB – NRV					
CSB – Northwestern					
CSB – Piedmont					
CSB – Rockbridge					
CSB – Valley					

The SCCPT in collaboration with the Commissioner shall develop a plan that addresses:

(i) the types, amounts, and locations of new and expanded community services that would be needed to successfully implement the closure or conversion of the state hospital to any use other than the provision of mental health services, including a six-year projection of the need for inpatient psychiatric beds and related community mental health services;

(ii) the development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs;

(iii) the creation of new and enhanced community services prior to the closure of the state hospital or its conversion to any use other than the provision of mental health services;

(iv) the transition of individuals receiving services in the state hospital to community services in the locality of their residence prior to admission or the locality of their choice after discharge;

(v) the resolution of issues relating to the restructuring implementation process, including employment issues involving state hospital employee transition planning and appropriate transitional benefits; and

(vi) a six-year projection comparing the cost of the current structure and the proposed structure.

B. The Commissioner shall ensure that each plan includes the following components:

1. A plan for community education;

2. A plan for the implementation of required community services, including state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas;

3. A plan for assuring the availability of adequate staff in the affected communities, including specific strategies for transferring qualified state hospital employees to community services;

4. A plan for assuring the development, funding, and implementation of individualized discharge plans pursuant to § **37.2-505** for individuals discharged as a result of the closure or conversion of the state hospital to any use other than the provision of mental health services; and

5. A provision for suspending implementation of the plan if the total general funds appropriated to the DBHDS for state hospital and community services decrease in any year of plan implementation by more than 10 percent from the year in which the plan was approved by the General Assembly.

C. At least nine months prior to any proposed state hospital closure or conversion of the state hospital to any use other than the provision of mental health services, the state and community consensus and planning team shall submit a plan to the Joint Commission on Health Care and the Governor for review and recommendation.

D. The Joint Commission on Health Care shall make a recommendation to the General Assembly on the plan no later than six months prior to the date of the proposed closure or conversion of the state hospital to any use other than the provision of mental health services.

E. Upon approval of the plan by the General Assembly and the Governor, the Commissioner shall ensure that the plan components required by subsection B are in place and may thereafter perform all tasks necessary to implement the closure or conversion of the state hospital to any use other than the provision of mental health services.

F. Any funds saved by the closure or conversion of the state hospital to any use other than the provision of mental health services and not allocated to individualized services plans for individuals being transferred or discharged as a result of the closure or conversion of the state hospital to any use other than the provision of mental health services shall be invested in the Behavioral Health and Developmental Services Trust Fund established in Article 4 (§ **37.2-317** et seq.).

G. Nothing in this section shall prevent the Commissioner from leasing unused, vacant space to any public or private organization.

Appendix A
Transformation Team Recommendations

ADULT BEHAVIORAL HEALTH	
SERVICES	
Crisis Response Services	• Ensure adequacy of emergency service/crisis continuum of care interventions • Medically supervised detoxification in a variety of settings
Prevention	• Offer screening/assessment referral services • Promote wellness activities
Case Management	• Mandate case management with caseload standards • Offer peer provided services and recovery supports • Outpatient (OP) counseling/therapies • Medication assisted treatment
Coordination of Services	• Focus on public clients with both high physical health (PH) and behavioral health (BH) needs • Strengthen case manager/ practitioner sills in understanding and coordinating care • Co-locate primary care in CSB settings • Support CSBs becoming health homes for persons with serious mental illness (SMI) and chronic serious co-morbid physical health conditions • Use community health workers to conduct outreach • Explore ways to better support employment services • Convene work group with private hospitals, CSBs, and the DBHDS to develop strategies to better serve clients denied admission because of co-morbid conditions or behavioral health challenges
ACCESS	
Adopt Industry Standards	• Review the continuum of services that DMAS currently funds in light of the goals and priorities of the DBHDS • Reestablish a personal level of support level • Adopt industry standard access targets to measure the progress of the system in increasing access • Increase basic substance use disorder (SUD) treatment capacity
Use Data to Drive Care and Policy Decisions	• Assure use of validated assessment tools for co-occurring disorders in both SUD and mental health (MH) programs • Develop strategy for utilizing data • Expand Secretary's dashboard to include "real life" outcomes measures like housing stability, employment and community integration
Work to Appropriately Fund Services	• Reevaluate Medicaid rates for all SUD services • Explore Medicaid reimbursement for persons under an emergency custody order/temporary detention order (ECO/TDO) • Leverage Federal Medicaid funds for innovative services/services for uninsured • Establish rotating discretionary fund to provide one-time assistance to peer-run organizations • Align use of DMAS and DBHDS funding to support integrated approach
Strengthen the Workforce	• Require organizational self-assessment by all providers of publicly funded BH • Improve identification of SUD issues by requiring specific continuing medical education (CME) for licensed healthcare professionals • Conduct workforce assessments re: provider availability and capabilities

JUSTICE INVOLVED	
SERVICES	
Prevention	• Judges need to receive education on the Risk-Need-Responsivity model of risk management. Judges need to better understand the screening process, what the research shows about the positive effect of diverting low-risk offenders, and to be trained in how to use the risk screening as a guide in determining level of supervision
Coordination of Services	• Develop mechanisms for notification (upon entry to the facility) and ongoing communication between jails/detention centers/correctional centers and CSBs to allow for a more seamless transition from jail/detention center/correctional center back to the community
ACCESS	
Adopt Industry Standards	• All individuals with BH needs need to have access to psychotropic medications • A system for the prompt screening, assessment and identification of individuals with BH and/or ID/DD issues needs to be in place in every jail, detention center and correctional center • Standards should be set requiring jails/detention centers/correctional facilities to have a certain percent of their staff who have received advanced training in BH and intellectual disability/developmental disability (ID/DD) issues (to include identifying individuals with MH/ID/DD issues, responding therapeutically to individuals with MH/ID/DD issues and responding to individuals in crisis) • Localities should be supported in developing mental health dockets • There should be a statute in the code to allow judges to order pre-trial mental health evaluations to aid judges in making bail/bond determinations • There needs to be an oversight system of evaluators who conduct pre-trial evaluations to ensure the evaluations meet the standard of practice
Work to Appropriately Fund Services	• Jails, detention centers and correctional centers need more capacity to provide a minimum standard of BH (compared to OP level)
Strengthen the Workforce	• All law enforcement agencies should have Crisis Intervention Team (CIT) programs

Appendix B: Report on Item 314.B.I (2014)

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Item 314.B.1. – Report on the Commonwealth's Utilization of State Hospitals

to the Governor and Chairmen of House Appropriations and Senate Finance Committees

November 5, 2014

Review of the Commonwealth's Utilization of State Hospitals

I. Appropriation Act:

Introduction

Item 314 B.1. of the 2014 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to submit to the Governor and the Chairmen of the Senate Finance and House Appropriations Committee a review of the current configuration of services provided at the Commonwealth's adult mental health hospitals, which considers options for consolidating and reorganizing the delivery of such state services. This review includes a programmatic assessment and fiscal impact of the long term needs for inpatient services for geriatric, adult, and forensic populations, the fiscal impact of the reduction in geriatric census on first and third party reimbursement at facilities, and the long term capital requirements of state mental health facilities. Paragraph B.2. requires DBHDS to establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible. This planning process will produce a comprehensive plan that ensures there are quality services, both inpatient and community-based, delivered at the community level in every part of the Commonwealth. The report on the planning process is due October 1, 2015.

Appropriation Language

Item 314 of the 2014 Appropriation Act states:

B.1. The Department of Behavioral Health and Developmental Services shall review the current configuration of services provided at the Commonwealth's adult mental health hospitals and consider options for consolidating and reorganizing the delivery of such state services. This review shall include: a programmatic assessment and fiscal impact of the long-term needs for inpatient services for geriatric, adult, and forensic populations; the fiscal impact of the reduction in geriatric census on first and third party reimbursement at facilities; and, the long-term capital requirements of state mental health facilities. The review shall also identify national best practices in the delivery of these types of services. The Commissioner, Department of Behavioral Health and Developmental Services, shall submit this review to the Governor and to the Chairmen of the Senate Finance and House Appropriations Committees by October 1, 2014.

2. The Commissioner, Department of Behavioral Health and Developmental Services, shall establish a planning process to provide geriatric, adult, and forensic mental health services, both inpatient and community-based, as close to persons' homes as possible. This planning process will produce a comprehensive plan that ensures there are quality services, both inpatient and community-based, delivered at the community level in every part of the Commonwealth. The target populations to be addressed in this plan are adults age 18 and older who: (i) have mental health needs, (ii) may have co-occurring mental health and substance abuse problems, (iii) may be in contact with the courts systems, (iv) may require emergency mental health services, (v) may need access to acute or intermediate inpatient psychiatric hospitalization, or (vi) may require long-term community behavioral health and other supports. The planning process should identify the mental health and substance abuse services and supports that are needed to help persons remain in their home and function in the community and should define the role that the Commonwealth's mental health hospitals will play in this effort. The plan should establish and rank recommendations for community and facility services and supports based on greatest priority and identify future estimated funding needs associated with each recommendation. The planning process shall include input from community services boards, state and private inpatient facilities, the Department of Medical Assistance Services, persons receiving mental health and co-occurring substance

abuse services, advocates for mental health and co-occurring services, and any other persons or entities the Department of Behavioral Health and Developmental Services deems necessary for full consideration of the issues and needed solutions. The Commissioner shall report to Governor and the Chairmen of the House Appropriations and Senate Finance Committees by October 1, 2015.

II. Background and Context

DBHDS Transformation Initiatives

DBHDS envisions a life of possibilities for all Virginians, and for our state to be a model system for behavioral healthcare for all who need its services. To that end the DBHDS Commissioner initiated a comprehensive review of the state behavioral health safety net to develop plans for a system of care that ensures both inpatient and community based quality care across the lifespan in every part of the Commonwealth. The current system has challenges, as the public behavioral health system is at a crucial point, presenting an unprecedented opportunity to truly transform our system to the benefit of those we serve. A transformed system focused on access, evidence-based interventions, stewardship of resources, and accountability, will instill confidence in our response during times of crisis and inspire hope for the promise of recovery for everyone.

First and foremost, the Commonwealth's public behavioral health system must be grounded in the principle that people can and do recover from serious mental illness, that effective treatment is available, and that treatment works. Second, there must be access to services. There should be a high-quality continuum of services that are consistently available across the Commonwealth. To best promote recovery, interventions should be holistic, and include the necessary primary health care, housing and employment supports. Services must be individualized, consumer-driven and family-focused. Interventions should be focused on prevention and early intervention. A transformed system must include a well-functioning and responsive safety net for individuals in crisis as well as their family members. DBHDS, in collaboration with community partners, must ensure that the emergency service system responds appropriately and effectively every single time.

A comprehensive and responsive behavioral health system of care will require a significant investment in wellness, prevention, early intervention, and core treatment services to provide for a continuum of care which is easily accessible. Fifty percent of all lifetime cases of mental illness begin by the age of 14, and 75 percent by the age of 24. The average delay between onset of symptoms and intervention is eight to ten years. Additionally, DBHDS recognizes the need to further invest in substance abuse treatment, resources for children and young adults. This continuum would include housing and employment supports because these are an integral part of sustaining individuals and families in the community. These programs are highly effective and promote sustainable recovery.

In order to effectively review the current configuration of state mental health hospitals and options for consolidating and reorganizing the delivery of state services, it is necessary to further develop the DBHDS vision of a comprehensive and responsive system of care, the development of a comprehensive plan and timeline for implementation. The DBHDS is committed to a full-scale, comprehensive system transformation effort. This includes an increased emphasis in the key areas of accountability, transparency, strengthening communication among all stakeholders, collaboration with community partners, and systemic implementation of best practices.

The DBHDS will call on national experts for recommendations and lessons learned across the country. Additionally, the DBHDS will incorporate recommendations from previous efforts in Virginia, such as the prior work of the Commission on Mental Health Law Reform, the Virginia Tech Review Panel, the

Taskforce on School and Campus Safety and the recommendations from the Governor's Taskforce on Improving Mental Health Services and Crisis Response.
This transformation will occur in phases. In the first phase, Commissioner Ferguson has convened small transformation teams for the behavioral health services system to begin developing a strategic plan for services, delivery and infrastructure. The teams will focus in four areas initially, including:

- Adult behavioral health
- Adult developmental services
- Children's behavioral health
- Justice-involved behavioral health and developmental disability services

These teams will advise the Commissioner on the best practices, structures, and ideas to transform the system. The Commissioner's aim is to identify the structures and processes that will aid, enhance and expand the delivery of behavioral health services across the Commonwealth. As the teams get underway, the Commissioner will establish goals for key deliverables for 6, 12, 18 and 24 months. Each group will keep the Commissioner informed of their key findings and developments.

III. Evolving Role of State Mental Health Hospitals

Current Role of State Mental Health Hospitals In Continuum of Care

DBHDS is committed to excellence in psychiatric care in our state mental health hospitals. The role of the state hospital should be to serve as the safety net for individuals with serious mental illness and/or co-occurring disorders throughout the Commonwealth. DBHDS mental health hospitals are only one component of a continuum of public behavioral health services, which provides a safety net for all citizens of the Commonwealth. State mental health hospitals provide the most intensive and most costly services to individuals and serve 2 percent of those receiving behavioral health services from the public sector of care. At the present time, 11 percent of the state mental health hospital capacity is used by 150 individuals who have been clinically ready for discharge more than 30 days, but have extraordinary barriers that prevent them from being reintegrated in their community in a timely manner. For many of these individuals the needed array of community based services does not exist. Twenty-eight individuals remain in our state hospitals even though they have been ready for discharge more than 365 days.

These individuals could and should be served in the community if there were sufficient, willing providers and a comprehensive continuum of community-based services. Nursing homes and assisted living facilities are often reluctant to admit individuals from our state hospitals due to the complexity of their medical and behavioral health issues and their inability to access behavioral health support. The DBHDS is developing plans to provide access to behavioral health supports for nursing homes and assisted living facilities. This is just one example of the transformational projects DBHDS is implementing. Until the Commonwealth develops the infrastructure and strong working relationships with private providers to transition these individuals to the community, the state mental health hospitals will continue to be used as a long term care placement when a less secure and more integrated placement is appropriate.

The DBHDS mental health hospitals play a major role in providing behavioral health care to individuals with serious mental illness who are involved with the criminal justice system. Overall, 34 percent of state mental health hospital beds are used for this purpose. Over the past four years, DBHDS has experienced a slow, but steady increase in the number of forensic admissions, a trend seen in many states. Despite this, in FY 2014 DBHDS saw an overall decrease in the number of forensic bed days, which may suggest that the periods of hospitalization appropriately and efficiently addressed the psycho-legal issues which resulted in the hospitalization. Individuals adjudicated Not Guilty by Reason of Insanity (NGRI) continue

to use the highest number of forensic bed days. Admissions for the purpose of restoring individuals

Competency to Stand Trial continue to be the forensic category for which DBHDS admits the greatest number of forensic clients. Aligned with our commitment to community-based care, the DBHDS is continuing to work with community providers to safely reduce and divert forensic admissions from state hospitals, increase conditional releases, and the reintegration of individuals with justice-involvement into the community. This effort is possible through the ongoing development of community-based forensic expertise. The DBHDS has significantly increased the capacity and the capabilities of community-based evaluators by providing community forensic training and recommended forensic evaluation. In addition, the DBHDS continues to expand outpatient restoration services and enhance outpatient forensic evaluations to decrease forensic pressures on state hospital admissions.

We have witnessed an increase in the number of competency restoration referrals to CSBs to provide the service on an outpatient basis, thus preserving inpatient beds. We anticipate with the additional training and resources provided to CSBs this year we will see a further increase in the number of outpatient competency restoration cases in FY 2015.

Current Configuration of State Mental Health Hospitals

As part of the public sector continuum of care, DBHDS mental health hospitals work collaboratively within regional partnerships to serve as the safety net for individuals with serious mental illness (SMI) across the life span. Hospital staff maintains strong relationships with Community Services Boards (CSB) and private providers to manage the state hospital census and ensure that a bed is always available for individuals with SMI who are in crisis. The average length of stay and number of admissions varies by hospital, which partially reflects the needs of the community.

Catawba Hospital

Catawba Hospital is located in Roanoke County, Virginia. The facility specializes in serving adult and geriatric patients needing behavioral health care. Catawba Hospital offers dedicated acute care and extended care geriatric treatment. The first priority of Catawba Hospital is to help individuals in their care regain and maintain their highest level of mental and physical functioning, with the ultimate goal of returning to community living. Catawba Hospital primarily provides treatment for adults in Partnership Planning Region VII, which includes two CSBs (Blue Ridge Behavioral Health and Alleghany Highlands). The current bed operational capacity and admission statistics are as follows:

Catawba Hospital	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 - 8/31/14
Adult	50	Civil	112	64	9
		Civil TDO	37	62	29
		Forensic TDO	13	16	2
		Other Forensic	11	14	1
		Adult Total	**173**	**156**	**41**
Geriatric	60	Civil	48	37	2
		Civil TDO	22	40	16
		Forensic TDO	1	4	1
		Other Forensic	5	7	3
		Geriatric Total	**76**	**88**	**22**
Catawba Hospital Total	**110**		**249**	**244**	**63**

Central State Hospital
Central State Hospital (CSH) is located in Dinwiddie County, Virginia and responds, in partnership, to the mental health needs of individuals in Health Planning Region IV (HPR IV). Central State Hospital provides the only maximum-security forensic psychiatry for the entire Commonwealth and provides a safety net for individuals requiring behavioral healthcare in that region. The civil adult treatment program at CSH provides extended treatment to clients over 18 years of age from the Central Virginia area. The services provided range from short term, quick re-entry to the community, to long-term intensive treatment for individuals with the most severe SMI. While CSH does not maintain an acute care unit, they collaborate with community partners to serve as a safety net and accept TDOs until the individual can be transferred to a private provider.

Central State Hospital serves adult civil commitments for six CSBs (Chesterfield, Crossroads, District 19, Goochland-Powhatan, Hanover, and Henrico Area). The current bed operational capacity and admission statistics are as follows:

Central State Hospital	**Bed Capacity**	**Type of Admissions**	**FY13**	**FY 14**	**FY 15** 7/1/14 - 8/31/14
Adult Civil	100	Civil	26	29	4
		Civil TDO	44	54	9
Forensic	177	Forensic TDO	87	94	22
		Other Forensic	357	336	65
		Adult Total	**514**	**513**	**100**
		Geriatric Forensic TDO	0	2	0
		Other Forensic	0	6	3
		Geriatric Total	**0**	**8**	**3**
CSH Total	**277**		**514**	**521**	**103**

Eastern State Hospital

Eastern State Hospital (ESH) is located in James City County, Virginia. In April 2008, the Hancock Geriatric Treatment Center introduced a new, smaller, state-of-the-art setting, followed by the September 2010 opening of the adult mental health treatment center. As part of Virginia's public mental health system, ESH serves adults, between the ages of 18 and 64, as well as individuals age 65 and above in Health Planning Region V (HPR-V). ESH primarily provides treatment for individuals in HPR V which includes eight CSBs (Chesapeake, Colonial Behavioral Health, Eastern Shore, Middle Peninsula-Northern Neck, Norfolk, Portsmouth, Virginia Beach and Western Tidewater). The current bed operational capacity and admission statistics are as follows:

ESH	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 - 8/31/14
Adult Civil	90	Civil	38	54	11
		Civil TDO	11	34	13
Forensic	127	Forensic TDO	19	36	3
		Other Forensic	159	161	27
		Adult Total	**227**	**285**	**54**
Geriatric	80	Civil	6	5	1
		Civil TDO	2	5	13

		Forensic TDO	2	1	0
		Other Forensic	5	8	1
		Geriatric Total	**15**	**19**	**15**
ESH Hospital Total	**297**		**242**	**304**	**69**

Northern Virginia Mental Health Institute

Northern Virginia Mental Health Institute (NVMHI), located in Falls Church, Virginia provides mental health treatment for individuals living in Northern Virginia. NVMHI accepts individuals on involuntary and/or voluntary admission status. NVMHI provides treatment for individuals between the ages of 18 and 65, who are in need of acute psychiatric treatment and reside in one of the five CSBs in Northern Virginia (Arlington, Alexandria, Fairfax-Falls Church, Loudoun, and Prince William). The current bed operational capacity and admission statistics are as follows:

NVMHI	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 - 8/31/14
Adult Civil	96	Civil	516	468	118
		Civil TDO	159	62	13
Forensic	38	Other Forensic	18	16	2
NVMHI Total	**134**		**693**	**546**	**133**

Piedmont Geriatric Hospital

Piedmont Geriatric Hospital (PGH) located in Burkeville, Virginia, is the only state facility that exclusively treats geriatric persons, individuals 65 years of age or older, in need of inpatient treatment for serious mental illness, meet the requirements for voluntary or involuntary admission, and do not have a medical condition that requires priority treatment in an acute care hospital. The current bed operational capacity and admission statistics are as follows:

PGH	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 - 8/31/14
Adult		Civil	1	1	
Geriatric	123	Civil	43	39	
		Civil TDO	5	15	
		Forensic TDO	1	1	
		Other Forensic	9	18	
PGH Total	**123**		**59**	**74**	

Southern Virginia Mental Health Institute

Southern Virginia Mental Health Institute (SVMHI), in Danville, Virginia provides person-centered, individualized treatment using the principles of recovery to promote hope, self-determination, and empowerment. The primary goal is to maximize favorable outcomes for individuals served to ensure their successful reentry to their chosen community. Essential elements of treatment focus on self-direction, respect, responsibility, and the use of peer support. The treatment at SVMHI is holistic and strength-based. SVMHI provides treatment for adults with SMI for three CSBs (Danville-Pittsylvania, Piedmont, and Southside). The current bed operational capacity and admission statistics are as follows:

SVMHI	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 -

					8/31/14
Adult Civil	48	Civil	69	107	15
		Civil TDO	157	160	21
Forensic	24	Forensic TDO	11	14	3
		Other TDO	24	29	3
SVMHI Total	**72**		**261**	**310**	**42**

Southwestern Virginia Mental Health Institute

Southwestern Virginia Mental Health Institute (SWVMHI) is located in Marion, VA. SWVMHI, in collaboration with the local CSBs, works together to be the region's center for excellence in the treatment of serious mental illness. SWVMHI is a values-driven organization. This is demonstrated through training, identifying priorities, communication, and commitment in the quality of care provided to those they serve. SWVMHI primarily provides treatment for individuals in HPR III which includes six CSBs (Cumberland Mountain, Dickenson County, Highlands, Mount Rogers, New River Valley, and Planning District 1). The current bed operational capacity and admission statistics are as follows:

SWVMHI	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 - 8/31/14
Adult Civil	125	Civil	126	80	16
		Civil TDO	512	585	93
		Forensic TDO	7	31	2
		Other Forensic	27	24	6
		Adult Total	**672**	**720**	**117**
Geriatric	41	Civil	6	6	0
		Civil TDO	35	44	8
		Other Forensic	7	2	0
		Geriatric Total	**48**	**52**	**8**
SWVMHI Total	**166**		**720**	**772**	**125**

Western State Hospital

Western State Hospital (WSH) is located in Staunton, Virginia. In 2013, a new state-of-the-art, $140.5 million facility opened and patients were successfully transitioned from the old facility to the new one. The design of the new hospital incorporates special features that facilitate the delivery of highly-specialized, recovery-oriented treatment and provides a secure environment. This new setting not only enhances the provision of treatment, but also supports the development of the life skills needed for living independently within the community upon discharge. Western State Hospital primarily provides treatment for individuals in HPR I which includes eight CSBs (Horizon, Harrisonburg –Rockingham, Northwestern, Rappahannock Area, Rappahannock-Rapidan, Region Ten, Rockbridge Area, and Valley). The current bed operational capacity and admission statistics are as follows:

WSH	**Bed Capacity**	**Type of Admissions**	**FY 2013**	**FY 2014**	**FY 2015** 7/1/14 - 8/31/14
Adult Civil	216	Civil	254	296	42
		Civil TDO	25	56	25
Forensic	28	Forensic TDO	83	108	16
		Other Forensic	168	211	51

WSH Total	244		530	671	143

Total Admissions for All State Hospitals:

FY 2013	FY 2014	FY 2015 (YTD)
3,959	4,275	803

In summary, the number of admissions to state mental health hospitals for FY 2013 averaged 330 per month. For FY 2014 the average number of admissions to state hospitals was 356 per month. For the first two months in FY 2015 the average number of admissions to all state hospitals is currently 401.5 per month.

The associated expenses and revenues for each of the state mental health hospitals is described below.
Revenues, Appropriations, and Expenditures for State Mental Health Hospitals

Facility	FY 2014 Revenues	FY 2014 Appropriations	FY 2014 Expenditures
Catawba Hospital	$ 10,566,171	$21,779,294	$ 21,779,294
Central State Hospital	$ 198,871	$49,591,872	$ 49,572,499
Eastern State Hospital	$ 19,391,089	$67,993,007	$ 65,766,984
Northern Virginia Mental Health Institute	$ 1,890,093	$26,760,623	$ 26,749,943
Piedmont Geriatric Hospital	$ 22,877,410	$24,178,882	$ 24,178,882
Southern Virginia Mental Health Institute	$ 1,798,227	$13,419,350	$ 13,033,052
Southwest Virginia Mental Health Institute	$ 9,701,414	$34,184,048	$ 34,181,225
Western State Hospital	$ 5,809,196	$52,745,206	$ 52,739,210
Total	**$ 72,232,471**	**$290,652,282**	**$288,001,089**

Note: Revenues represent only what these facilities have generated in terms of reimbursement. The General Fund appropriation is not included. Appropriations adjusted for central accounts distributions.

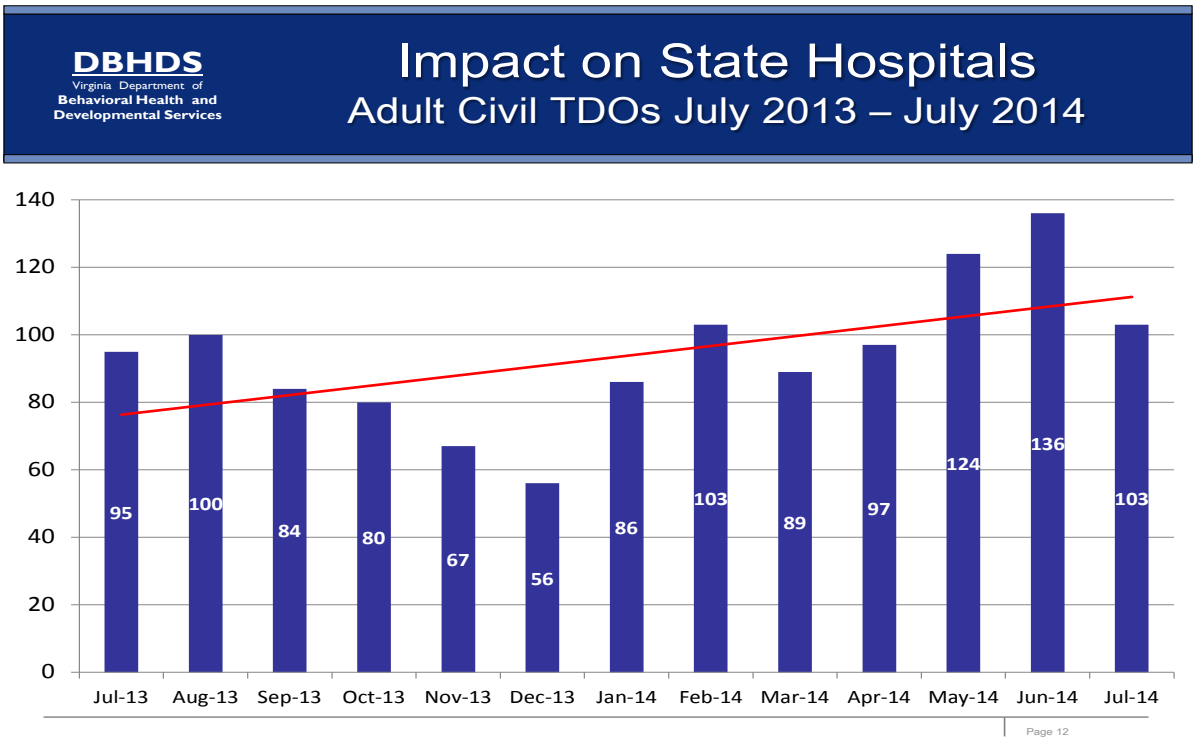
Impact of 2014 Changes to Civil Commitment Laws

The 2014 General Assembly Session passed a number of legislative changes to Virginia's civil commitment laws that went into effect on July 1, 2014. The implementation of the new legislation established state mental health hospitals as the facility of last resort. This change has significantly impacted the role of state mental health hospitals within the continuum of care. In the six months leading up to the implementation of these changes, overall admissions to state mental health hospitals increased by 24 percent. However, the rate of increase varied by the population served – adult beds experienced an 18 percent increase, child and adolescent beds experienced a 46 percent increase, and geriatric beds experienced a 42 percent increase. Due to robust treatment and appropriate discharge into the community, there was not a commensurate increase in overall state mental health hospital census.

In the first two months following the implementation of the new civil commitment laws, overall admissions to state mental health hospitals increased by 19.4 percent. However, once again the rate of

increase varied by the population served – adult beds had a 14 percent increase, child and adolescent beds had a 30 percent increase, and geriatric beds had a 65 percent increase.

The July 1, 2014 changes to the civil commitment laws significantly altered the role of the state mental health hospitals in the emergency custody and temporary detention process. Among other procedural changes, state mental health facilities will now admit all individuals who need involuntary temporary detention for whom no alternative facility can be found. These "last resort" provisions can complicate access to and coordination of needed care under certain conditions (e.g., individuals with co-morbid psychiatric and medical issues, brain injury, etc). DBHDS is collecting data on these cases in order to understand the impact of these changes and potential improvements that would support the delivery of appropriate care in a timely and efficient manner.



Data interpretation and trend projections are complicated by the variable impact of the new laws for each of the four major populations served by DBHDS: child and adolescent, adult, geriatric, and forensic individuals. DBHDS will continue to collect and analyze data and ensure that the transformation efforts incorporate all available information in its recommendations. These efforts will result in recommendations and options for consolidating and reorganizing the delivery of state mental health hospital services.

National Best Practices for the Role of State Mental Health Hospitals

The DBHDS transformation efforts will continue to review the current configuration of state mental health hospitals, data regarding the impact of the new legislation for state mental health hospitals, and national literature on the role of state mental health hospitals in the continuum of behavioral health care services. The National Association of State Mental Health Hospital Directors (NASMHPD) recently published a technical report called "The Vital Role of State Psychiatric Hospitals" (NASMHPD, 2014). In this report, NASMHPD advocates for state mental health hospitals to play a unique role in the continuum of the treatment and recovery services that are available within a robust continuum of

community-based services. Community supports are recognized as essential components of a strong public mental health safety net system, which allows many individuals to avoid hospitalization in state hospitals, supports wellness, and provides for early intervention. This recognizes that many individuals with serious mental illness will need services that are provided only through the expertise of state mental health hospitals, but also emphasizes that numerous individuals can avoid admission to a state mental health hospital when early intervention and appropriate continuum of care is easily accessible in their communities.

The NASMHPD report found that health care reform (which has increased access to private inpatient capacity which indirectly increases demand on the public sector capacity since private beds are full), economic restraint, complex civil commitment laws, and the need to ensure civil rights have placed pressures on the capacity and adequacy of state mental health hospitals. Additionally, due to the history of deinstitutionalization and the development of comprehensive community mental health systems, the number of residents in state psychiatric hospitals has declined by 92 percent from 1950 to 2012. During this same 62-year period, the number of state mental health hospitals has declined by 36 percent. Like the Commonwealth, many states are working to build community-based mental health treatment and recovery support systems. However, similar to Virginia, NASMHPD found that the increased capacity for community based mental health services has been insufficient to accommodate the level of community resources required to serve the number of individuals in need of mental health treatment.

Currently, there are 207 state-operated mental health hospitals nationwide, serving approximately 40,600 people at any given point in time. The average state mental health hospital has about 200 individuals served on any given day. The most common populations are adults, the elderly, and forensic patients. There is a great deal less variability in the use of state hospitals for acute care (fewer than 30 days), intermediate care (30 to 90 days), and long-term care (more than 90 days). Intermediate care is the most common, followed closely by long-term and then short-term care. Individuals admitted into state mental health hospitals can be admitted voluntarily, civilly committed, or committed by a criminal court.

In 1999, the Supreme Court's *Olmstead* decision reaffirmed the civil rights granted to individuals within the scope of the *American Disabilities Act (ADA)* of 1990 and the *Civil Rights of Institutionalized Persons Act (CRIPA)* of 1980. These two federal laws collectively protect the rights of individuals with disabilities to live in the least restrictive, most integrated community settings possible. Numerous states have been investigated by the U.S. Department of Justice (DOJ) as well as various state Protection and Advocacy (P&A) groups for violating standards promulgated under the *Olmstead* ruling, resulting in settlement agreements designed to transition individuals into less restrictive settings, and placements which integrate the individual to the greatest degree possible within the community. In January 2012, Virginia and the DOJ entered into a settlement agreement covering individuals with intellectual and developmental disabilities. Virginia is potentially vulnerable to a DOJ investigation of its adult and geriatric state mental health hospitals as it relates to individuals who could thrive in integrated community settings given the proper array of community based services and supports.

Nationally, the combination of states with established *Olmstead* Plans and those with settlement agreements have led to the broad expansion of community-based services, integrated care, and supported housing options. The *Olmstead* decision emphasizes that if a person should need care for disabilities, including people with serious mental illness, the treatment and care should be provided in the *least restrictive*, and *most integrated* setting possible. It is important that during the DBHDS transformation planning, Virginia develop a strong strategic plan for the development of community-based services consistent with the *Olmstead* decision.

As states have downsized their state mental health hospitals, two types of involuntary treatment clients -- forensic clients and sex offenders committed to the state hospital -- have grown as a share of the clients

served by state mental health hospitals. In FY 1983, state mental health hospitals expended 7.6 percent of their funds on forensic services. By FY 2012, the share of state mental health hospital expenditures for individuals with forensic status had grown to 36 percent. It is anticipated that the state mental health hospitals role in addressing the needs of justice involved individuals will continue to increase.

All individuals served in state mental health hospitals should be considered in the process of recovery. Every individual who is committed to a state mental health hospital, forensic or otherwise, needs to be evaluated as an individual in terms of inpatient goals, risks, and benefits in order to determine if this same treatment could be safely provided in the community. State hospital services should be recovery-oriented and evidence-based for patients with complex psychiatric conditions who are at risk of harm to self or others and who cannot be effectively treated by existing services in the community.

A shared safety net is when a state implements an accessible and comprehensive continuum of care between hospital-based care and community-based care to meet a wide range of needs for individuals and families in crisis. To ensure continuity of care, state hospital services should be integrated within the continuum of community services so that individuals are served in the community wherever possible and appropriate. Safety net goals are aligned with the *Olmstead* tenets.

The majority of persons served in state psychiatric hospitals have experienced trauma that is often a major cause of their suffering. As such, state psychiatric hospitals should utilize trauma-informed care. Trauma-informed practices are policies, procedures, interventions, and interactions among clients and staff that recognize the likelihood that a person receiving services has experienced trauma or violence. In a trauma-informed program, everyone, regardless of job level or specific role, is educated about trauma and its consequences. The goal is to create an inviting environment of respect and safety that promotes healing and prevents the need for seclusion and restraint.

A well-trained, professional and paraprofessional workforce is paramount in ensuring quality care. State psychiatric hospitals cannot maintain safe environments and provide effective treatments with perpetually high vacancy rates of professional staff and lack of staff training. Staff vacancies are often an indicator of underfunding. State salaries must be competitive with the healthcare market for mental health professionals and health care administrators. State psychiatric hospitals should promote, enhance, support and strengthen the skill levels of all staff, including offering Continuing Education Credits. State psychiatric hospitals should strive to have teaching relationships with various professional fields including, but not limited to, psychiatry, psychology, nursing, direct care, social work, counseling and primary care.

In summary, national literature, and the NASMHPD reports recognize the unique role state mental health hospitals have in the continuum of the treatment and recovery services that are available to individuals. Any consolidation or reorganization of state mental health facilities must be done with an understanding of the current community based service system. These community supports are essential components of a strong public mental health safety net system, which allows many individuals to avoid hospitalization in state hospitals, supports wellness, and provides for early intervention. The DBHDS transformation efforts will provide recommendations and options for consolidating and reorganizing the delivery of state mental health hospital services within the context of existing and recommended array of community-based services.

IV. Physical Plant and Capital Outlay Considerations for State Mental Health Hospitals

<u>Physical Plant Conditions of State Mental Health Facilities</u>

Physical Plant Overview

DBHDS is responsible for the operation of ten state-owned mental health facilities. The state hospitals, along with Hiram Davis Medical Center (HDMC), have approximately three million square feet of building area with an average age of nearly 50 years. Lack of adequate maintenance reserve funding continues to present problems for these older structures.

These facilities consist of over 200 individual buildings served by a variety of mechanical heating and cooling systems ranging from central plant distribution systems to individual package heating and cooling units and in some instances makeshift systems. Replacement of these systems based on age and physical condition has typically been deferred due to an uncertainty of the long-range need for continued use of the buildings. Many buildings anticipated to remain in use for a defined duration have reached the point of requiring an investment to maintain reliable systems for the duration of their use. Buildings that may reach surplus status require conditioned environments to prevent deterioration, therefore enhancing possible future utilization. Although substantial critical system improvements have been achieved in recent years, a substantial backlog of potential system failures and system inefficiencies remain.

Following is a building condition assessment for the adult mental health facilities:

Large Facilities

Eastern State Hospital: The campus currently contains approximate 747,000 square feet of buildings, of which 284,000 square feet has been declared surplus and is in the process of being sold. The remaining 463,000 square feet includes the Hancock Geriatric Treatment Center (opened in 2008) and the Adult Mental Health Treatment Center (opened in 2010) accounting for 300,000 square feet of space excellent condition. The remaining 163,000 square feet are older structures that are used for support functions and will need modernization in the near future. The overall condition of this facility is very good.

Western State Hospital: The former campus has been sold to the City of Staunton's Industrial Development Authority. The new, replacement hospital is complete and in operation. It provides approximately 360,000 square feet of the most modern and appropriate mental health facilities in the country. This new hospital cost approximately $130 million. The overall condition of this facility is excellent. The facility has a capacity of 246. Provision for expansion is pre-planned and built-in. An additional 56 beds can added in the future.

Central State Hospital: This hospital operates in many buildings that are old and beyond their useful life. Pre-planning funds have been approved to replace many of these buildings with a new 300-bed facility similar to the new, Western State Hospital. The current condition of this facility is poor.

Southwestern Virginia Mental Health Institute: The main treatment area contains approximately 100,000 square feet and was constructed in 1988. This building has recently received a new fire alarm and security system. Also, the main administration building is housed in a building that is listed on the National Historic Registry and was constructed in 1887. It received a new roof and skylight this year. In addition to these two buildings, the 110 acre campus contains 15 other buildings varying in age from 1910 to 1970. Some buildings have been vacated and are no longer in use. The campus water supply system is extremely old and in need of complete replacement. This campus will

continue to need maintenance reserve funding commensurate with the age of the structures, however, the overall condition of the facility is good.

Regional Facilities

Northern Virginia Mental Health Institute: The original structure was constructed in 1975 and received a major addition and renovation in 1997. A re-roofing project was recently completed. The building is in good condition with the mechanical systems generally beyond the midpoint of their expected life. NVMHI will need ongoing maintenance commensurate with the building's age, but there are no plans to make major changes to the building structure. The building is located on 10 acres of property with no opportunity for growth. It is surrounded on three sides by residential development and on the other side by INOVA Hospital. The overall condition of the facility is good.

Southern Virginia Mental Health Institute: The structure was built in 1975 and received a major upgrade of its mechanical systems and interior finishes in 2010. Several years ago the building received a new roof. The building contains 70,000 square feet and is situated on approximately 20 acres of land. The building's main parking lot is in need of replacement. Due to the age of the fire alarm and security systems, replacement of these system is currently in design. The overall condition of the building is very good.

Smaller Facilities

Piedmont Geriatric Hospital: This main hospital, Building 15, was constructed in 1939 and contains 27,000 square feet. In 1951, a 103,000 square foot addition added the north and west wings in 1951. Upgrades were made to the patient care area in 2011 to comply with the "Plan of Correction" approved by the Center for Medicare and Medicaid Services after an extensive audit of the facility showed numerous hanging hazards and other unsafe conditions in the building. Also, kitchen upgrades have been made as needed. The buildings mechanical, electrical and plumbing systems remain adequate, but are well beyond the midpoint of their expected life and will be in need of replacement in the near future. The exterior envelope of the building is failing. Extensive renovation is needed in the near future and planning for the repair of the exterior envelope has been completed and is awaiting authority to begin final design as funds are released.

Building 29 houses administration functions and contains approximately 35,000 square feet. It was constructed in 1950 as a nurse dormitory and has been adapted to the current use. Its mechanical systems are beyond their useful life and the building windows are in need of replacement. The remaining 23 buildings on campus range in age from 1924 to 1952. Many are vacant and unused.

The boiler plant has recently completed a major renovation that allows the facility to use renewable energy sources such as wood waste (i.e., sawdust) and native warm season grasses (i.e., switchgrass). This plant serves both the Piedmont Geriatric Hospital buildings and the Virginia Center for Behavioral Rehabilitation.
The overall condition of the facility is fair but the age of the buildings will require a great deal of maintenance.

Catawba Hospital: The hospital occupies 670 acres of property in a rural area of Roanoke County. It contains approximately 25 buildings constructed from 1910 to 1990. The main hospital building is

an eight-story structure constructed in 1953 and contains approximately 140,000 square feet. Several of the hospital floors are not occupied.

The building has recently received a major security systems and fire alarm system upgrade which are critical to assure safety. The building roof has recently been replaced. The mechanical systems are beyond their useful life and will require major renovation to bring them into compliance with modern standards. The heating, ventilation and air-conditioning systems are particularly challenging due to the low floor-to-floor height in the building. Windows were replaced several years ago and are very energy efficient, but on the patient floors these windows lack the security imposed in modern structures at Eastern State and Western State Hospitals.

Due to the remote nature of the site, this hospital has its own water treatment and sewage treatment facilities. The facility owns an extensive high voltage distribution system that must be maintained and makes it especially vulnerable to outages. The facility is served by its steam plant that is operated on fuel oil. While the facility is extremely well-maintained and operated with low energy usage, its inherent cost of energy makes it one of the most expensive to operate in the entire DBHDS system.
In addition to the Main Hospital, Building 15, there are approximately 25 other buildings on campus constructed between 1912 and 1996. The building that is in the best condition is the 9,000 square foot Patient Activities Building that was the most recently constructed. Many of the older buildings are vacant and abandoned. Efforts are underway to demolish several of the older buildings that are in a serious state of decay and contain hazardous materials.
The overall condition of the facility is fair.

DBHDS' six-year Capital Outlay Plan for mental health facilities includes the following:

- Replacement of CSH ($137.1 million)
- Expansion of WSH ($20.1 million)
- Renovation of PGH ($38.8 million)
- Renovate SVMHI ($10.2 million)
- ESH Phase III ($30.0 million)
- Renovation of CH ($45.9 million)
- Food service transformation ($23.2 million)
- Improvements at ESH to create a safe adult mental health environment ($2.4 million)
- Major system renovations for greater security ($8.4 million)
- Major renovation projects for roofs, infrastructure, abatement of hazardous materials and HVAC/boilers repairs and replacement ($34.9 million)

V. Fiscal Impact of Reduction in Geriatric Census

As the chart below demonstrates, the total geriatric census in our MH facilities has decreased 18 percentover the last 6 fiscal years; while the non-geriatric census has only decreased 10 percent.
Mental Health Facilities with a combination of both Geriatric and Adult Services

Year	Total Census (in bed days)	Geriatric Census (in bed days)	% of Medicaid Days	Expenditures	Revenue	Expenditures vs. Revenue
2008	286,275	149,130	63%	$ 151,241,129	$ 63,385,877	$ 87,855,252

2009	263,829	135,687	60%	$ 150,362,357	$ 63,282,808	$ 87,079,549
2010	251,789	137,043	62%	$ 145,349,147	$ 70,909,589	$ 74,439,558
2011	233,130	133,561	46%	$ 144,602,059	$ 48,309,947	$ 96,292,112
2012	223,230	124,283	55%	$ 142,539,521	$ 58,836,760	$ 83,702,761
2013	219,652	121,814	52%	$ 147,165,788	$ 53,579,238	$ 93,586,550
2014	224,302	99,125	44%	$ 145,906,385	$ 57,740,467	$ 88,165,918

This change in population mix has resulted in the total expenditures only decreasing 3 percent over this same time period while the revenue has decreased 15 percent. The small decrease in expenditures is a direct reflection of the standard operational costs for facilities. The facility with the largest decline in Medicaid Geriatric days is Eastern State Hospital. Utilized bed days fell from a high in 2008 of 41,334 to 23,243 in 2013 or a drop of 18,091. These factors have resulted in DBHDS' increased utilization of General Fund (7 percent) to take care of the individuals entrusted to our care. This is demonstrated by the increased need in General Fund appropriation at Eastern State based on the patient mix changes.

VI. Summary And Conclusions

DBHDS is committed to ensuring that the public mental health safety net is accessible for every individual or family in crisis. At this point, insufficient data is available to determine the impact of the recent legislation on the populations served by the state mental health hospitals. Additionally, considerable resources will need to be invested in state hospitals either in new construction or regular maintenance. Given the broad range of strategic planning, the transformational initiatives that are being launched, the realignment of resources, and the increased focus on specific populations, it is appropriate to provide more time for DBHDS to clarify the vision of the Commonwealth's public mental health care system in future years. In addition to the above considerations, any strategy to consolidate and reorganize state mental hospitals must factor in the financial impact of shifts in the mix of child/adolescent, adult, geriatric, and forensic populations served by these facilities.

Consistent with the *Olmstead* decision, the DBHDS remains committed to its mission of *A life of possibilities for all Virginians*. This mission is only attainable if a continuum of core services is accessible in every area throughout the Commonwealth. These core services must include wellness, prevention, early intervention, multiple levels of intensity in community based treatment, and a robust private sector engaged to serve the needs of diverse populations This continuum of services would also ensure a safety net is accessible and responsive to every individual and family in crisis, every time, and without fail.

As the Commonwealth develops additional community based resources, DBHDS anticipates that the state hospitals role will diminish over time. However, at this point, insufficient data is available to determine the impact of the recent legislation on the populations served by the state mental health hospitals. Additionally, considerable resources will need to be invested in state hospitals either in new construction or regular maintenance. Given the broad range of strategic planning, the transformational initiatives that are being launched, the realignment of resources, and the increased focus on specific populations, it is appropriate to provide more time for DBHDS to clarify the vision of the Commonwealth's public mental health care system in future years. In addition to the above considerations, any strategy to consolidate and reorganize state mental hospitals must factor in the financial impact of shifts in the mix of child/adolescent, adult, geriatric, and forensic populations served by these facilities. The role of state mental health hospitals within a community based system of care must be guided by and fully support the following principles:

- Individuals can and do recover from mental illness and substance use disorders.

- Across the entire Commonwealth, Virginians should have access to quality mental health services.
- Interventions should be focused on prevention and early intervention.
- Services must be individualized, consumer-driven and family-focused.
- To best promote recovery, interventions should be holistic, and include necessary primary health care, housing and employment supports.
- A safety net must be accessible and responsive to every individual and every family in crisis, every time, and without fail.

References

National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. (2014). *The Vital Role of State Psychiatric Hospitals.* Alexandria: NASMHPD Medical Directors Council. Retrieved September 22, 2014, from http://www.nasmhpd.org/Publications/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf